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In the Supreme Court of the United States

October Term, 1983

SOUTHEAST VOLUSIA HOSPITAL DISTRICT, et al.,
Appellants,

vs.

FLORIDA PATIENT'S COMPENSATION FUND, et al.,
Appellees.

ON APPEAL FROM THE SUPREME COURT OF FLORIDA

JURISDICTIONAL STATEMENT

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QUESTIONS PRESENTED BY THIS APPEAL

Does Section 768.54, Florida Statutes, as interpreted and applied by the State of Florida to require appellant hospitals to pay for unrelated physician malpractice liability, deny the hospitals equal protection of the laws in violation of the Fourteenth Amendment?

Does Section 768.54, Florida Statutes, as interpreted and applied by the State of Florida to require appellant hospitals to pay for unrelated physician malpractice liability, deprive the hospitals of property without substantive or procedural due process of law in violation of the Fourteenth Amendment?

LIST OF ALL PARTIES AND RELATED COMPANIES

The appellants are more than 100 Florida hospitals. They include for profit hospitals, charitable hospitals, not for profit hospitals and governmental hospitals. A listing of all parties to this appeal (and, where applicable, their parent companies, subsidiaries (except wholly owned), and affiliated corporations) is provided in the Appendix (A1).

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ON APPEAL FROM THE SUPREME COURT OF FLORIDA

JURISDICTIONAL STATEMENT

OPINIONS BELOW

The decision of the Supreme Court of Florida from which this appeal is taken was announced in a June, 1983 Order as *Department of Insurance v. Southeast Volusia Hospital District*, 8 FLW 196 (Fla. 1983) (A6), which stated that an opinion setting forth the reasons for the decision would follow. The opinion was published in September, 1983 as *Department of Insurance v. Southeast Volusia Hospital District*, 438 So.2d 815 (Fla. 1983) (A8). Rehearing was denied on November 4, 1983. The Supreme Court of Florida reversed the decision of Florida's First District Court of Appeal, *Southeast Volusia Hospital District v. Department of Insurance*, 432 So.2d 592 (Fla. 1st DCA 1983), *rev'd*, 438 So.2d 815 (Fla. 1983) (A19). The First District Court of Appeal had reversed the unreported final agency decision of Florida's Insurance Commissioner (A22) which incorporated the recommended order of the hearing officer (A54), rendered after Administrative proceedings held pursuant to Florida's Administrative Procedures Act, Chapter 120 Florida Statutes.

JURISDICTIONAL GROUNDS

This was an action by the appellant hospitals challenging the validity of Section 768.54(3)(c), Florida Statutes, as interpreted and applied by the Florida Insurance Commissioner in imposing certain assessments against the hospitals under the statute. The hospitals challenged the statutory assessments on the grounds, among others, that their rights under the equal protection and due process clauses of the Fourteenth Amendment to the United States Constitution were violated. The Federal constitutional questions were timely and continually raised by appellants.[1] On May 17, 1983, the First District Court of Appeal held for the hospitals on Florida constitutional grounds, stating for that reason that it did not reach the Federal constitutional claims. On June 9, 1983, the Supreme Court of Florida reversed, holding that Section 768.54, Florida Statutes, was constitutional on its face and as applied and stating that an opinion explaining its rationale and discussing other issues would follow. On September 15, 1983, the Supreme Court of Florida filed its opinion explaining its judgment of June 9, 1983, and on November 4, 1983, the Supreme Court of Florida denied appellants' timely motion for rehearing. The Notice of Appeal to this Court was filed on November 21, 1983, in the Supreme Court of Florida, and a copy was filed in the First District Court of Appeal.

Jurisdiction of this Court to review by appeal the decision of the Supreme Court of Florida is conferred by

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1. Under Florida law neither a hearing officer nor the agency head can decide questions of the constitutionality of a statute, those issues being appropriately determined upon judicial review of the agency decision. *Key Haven Associated Enterprises Inc. v. Board of Trustees of Internal Imp. Trust Fund*, 427 So.2d 153, 157, 158 (Fla. 1982). However, the constitutional issues were raised at the administrative level in this case as well as in the courts.

28 U.S.C. §1257(2). This is an appeal from a decision of the highest court of the State, which decided in favor of the validity of a Florida statute, the validity of which was drawn in question on the ground that it was repugnant to the Constitution of the United States. The following decisions sustain the jurisdiction of the Supreme Court to review the judgment on appeal in this case. *Stanton v. Stanton*, 421 U.S. 7, 95 S.Ct. 1373, 43 L.Ed.2d 688 (1975); *Duren v. Missouri*, 439 U.S. 357, 99 S.Ct. 664, 58 L.Ed.2d 579 (1979); *Orr v. Orr*, 440 U.S. 268, 99 S.Ct. 1102, 59 L.Ed.2d 306 (1979).

CONSTITUTIONAL AND STATUTORY PROVISIONS

The Fourteenth Amendment, the Constitution of the United States, provides in Section 1 as follows:

> All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

Section 768.54(3)(c), Florida Statutes (1977) provides as follows:

> (c) *Fees and assessments.*—Annually, each health care provider, as set forth in subsection (2), electing to comply with paragraph (2)(b) shall pay the fees established under this act, for deposit into the fund, which shall be remitted for deposit in a manner prescribed by the Insurance Commissioner. The cov-

erage provided by the fund shall begin July 1, 1975, and run thereafter on a fiscal year basis. For the first year of participation, each participating health care provider covered under the fund shall pay a fee for deposit into the fund in the amount of $1,000 for any individual, or $300 per bed, for any hospital. Those entering the fund after the fiscal year has begun shall pay a prorated share of the yearly fees for a prorated membership. The fee charged after the first year of participation shall consist of a base fee of $500 for any individual, or $300 per bed, for any hospital. The fees or assessments to be paid by those health care providers defined in subparagraphs (1)(b)5., 6., and 7. shall be established by the fund on an actuarially sound basis. In addition, after the first year of operation, additional fees shall be assessed, appropriately prorated for the portion of the year for which the health care provider participated in the fund, based on the following considerations:

1. Past and prospective loss and expense experience in different types of practice and in different geographical areas within the state;

2. The prior claims experience of the members covered under the fund; and

3. Risk factors for persons who are retired, semiretired, or part-time professionals.

Said base fees may be adjusted downward for any fiscal year in which a lesser amount would be adequate and in which the additional fee would not be necessary to maintain the solvency of the fund. Said additional fee shall be based on not more than two geographical areas with three categories of practice

and with categories which contemplate individual risk ratings for hospitals, for health maintenance organizations, and for ambulatory surgical facilities. Each fiscal year of the fund shall operate independently of preceding fiscal years. Participants shall only be liable for assessments for claims from years during which they were members of the fund; in cases in which a participant is a member of the fund for less than the total fiscal year, he shall be subject to assessments for that year on a prorata basis determined by the percentage of the year he participated. The fund shall be maintained at not more than $25,000,000 per fiscal year. Fees and refunds shall be set by the Insurance Commissioner after consultation with the JUA. Nothing contained herein shall be construed as imposing liability for payment of any part of a fund deficit on the JUA or its member insurers. If the fund determines that the amount of money in an account for a given fiscal year is not sufficient to satisfy the claims made against the account, the fund shall certify the amount of the projected insufficiency to the Insurance Commissioner and request the Insurance Commissioner to levy a deficit assessment against all participants in the fund for that fiscal year, prorated, based on the number of days of participation during the year in question. The Insurance Commissioner shall order such refund to, or levy such deficit assessment against, such participants in amounts that fairly reflect the classifications prescribed above and are sufficient to obtain the money necessary to meet all claims for said fiscal year. In no case shall any deficit assessment for a particular year against any health care provider other than a hospital exceed an amount equal to the fees or assessments originally paid by such health care

provider for participation in the fund for the year giving rise to such deficit assessment.

The original Act creating the Florida Patient's Compensation Fund, Chapter 75-9, Laws of Florida, appears in the Appendix at A87. The complete text of Section 768.54 Florida Statutes (1977) appears in the appendix at A76.

STATEMENT OF THE CASE

Introduction

In 1975, the Florida Legislature created the Florida Patient's Compensation Fund (Fund), a kind of group self-insurance, as a partial response to a perceived crisis in the availability of medical malpractice insurance. Section 768.54(3), Florida Statutes contains the provisions by which the Fund is financed. This statute (a) sets up a separate fund for each year, (b) contemplated that "fees" charged different classes of practitioners (such as surgeons, non-surgeons, hospitals, etc.) should actuarially reflect projected claims against those classes, (c) provides for an "assessment" procedure for any shortfalls,[2] also to fairly reflect the responsibility of the classes, and, by 1976 amendment, (d) set limits on "assessments" against physicians at an amount not to exceed "fees."

Under the statute, the Department of Insurance (Department, sometimes referred to as the Insurance Commissioner), on the application and recommendation of the

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2. The statute also contemplates refunds. Since each coverage year stands on its own financially, there will obviously be either an excess or a deficit each year because the actuarial estimates, while they can be close, cannot be 100% accurate.

Fund, is to set "fees" (other than a minimal statutory "base fee"), and, when the necessity for "assessments" arises, the Department is to set such "assessments" also upon application of the Fund. This case represents the first time that the Department has set "assessments" under the statute. This is a case of first impression, not only because these are the first "assessments," but also because the Department has never adopted any rules setting out the method or criteria for applying the statutory requirements for either "fees" or "assessments." Hence in this appeal the Court is asked to review the constitutionality of Florida's first interpretation of Section 768.54(3)(c).

For fund year 1977-1978, the Fund conducted no actuarial studies and requested no additional fees. Only the $500 base fee was charged to physicians. For fund year 1978-1979, the *Fund recommended* actuarially sound "fees" for physicians ranging from $1,700 to $12,600, depending on geographic area and category of practice. The *Department rejected* the Fund's recommended "fees" and set all physician "fees" at $500. Obviously, because actuarially inadequate fees were charged to physicians, it became probable that deficits or shortfalls would occur with respect to the physician classes, and for fund years 1977-1978 and 1978-1979 those deficits have now in fact occurred. In addition to the shortfalls for those two years which had occurred by the time "assessments" for those years were first requested (about $15 million), the actuarial projections in the record are that additional shortfalls of more than $100 million will occur on account of physician malpractice claims for the coverage years through 1981.[3]

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3. The actuarial projections released by the Fund in December 1983, showing the effect of this interpretation and application through *1982*, project that hospitals will be required to subsidize approximately *$190 million* of physician liability.

The issues before the Court arise because, in setting the "assessments" in the proceeding from which this appeal arises, the Department has adopted a statutory interpretation, now approved by the Supreme Court of Florida, which places the 1977-1978 shortfall *entirely* on the hospitals, although the entire shortfall is the result of *physician* malpractice losses, and which for 1978-1979 placed 85% of the physician losses on the hospitals. The actuaries say this result will occur for other coverage years as well. Obviously because of the dollars involved, this is a case of considerable importance to the appellants and it is important nationally because other states have similar patient compensation fund responses to the "malpractice insurance crisis," although none has as yet attempted to shift physician malpractice liability to others to the extent Florida has done.

Statement of the Case and Facts

By four orders dated January 13, January 22, February 1 and February 17, 1982, the Department of Insurance directed appellant hospitals to pay large assessments for deficits projected or accruing in the Fund for fund years 1977-1978 and 1978-1979. Petitioners challenged the assessments, requesting and receiving an administrative hearing before the State's Division of Administrative Hearings to challenge the assessments. On July 28, 1982, the Insurance Commissioner entered a Final Order adopting and fully incorporating the hearing officer's recommended order. The Final Order rejected appellants' challenge to the assessments.

Most of the pertinent facts in this case were stipulated in the Prehearing Stipulation (R. 3222-3249) and are capsulized in Exhibits P-50 and P-51 (R. 1297-1298). The following facts set out the basic picture of the issues now before the Court.

Prior to 1978, there were no actuarial studies by the Fund or the Department and no request by the Fund for additional fees. Thus only the $500 base fee was charged physicians for 1977-78. In 1978, the Fund retained the firm of Milliman & Roberts (actuaries) to recommend appropriate fees for fund year 1978-1979. The actuaries recommended the following fees:

	Statutory "Base Fees" Paid	Actuaries' *Recommended* Additional Fees	Additional Fees *Ordered* by Department
Class I Physicians			
Dade/Broward Co.	$ 500.00	$ 2,233.00	$ -0-
Rest of State	$ 500.00	$ 1,749.00	$ -0-
Class II Physicians			
Dade/Broward Co.	$ 500.00	$ 4,420.00	$ -0-
Rest of State	$ 500.00	$ 3,549.00	$ -0-
Class III Physicians			
Dade/Broward Co.	$ 500.00	$12,619.00	$ -0-
Rest of State	$ 500.00	$10,297.00	$ -0-

Prehearing Stipulation, #23.

Although the Department performed no independent actuarial study of the fees, it rejected the above recommendations, and as a result, physicians paid only the minimum "base fee" for 1978-1979.

The effect of the actuarially inadequate physician fees upon the hospitals became apparent when the final step of the fund financing began during the "assessment" pro-

cess. Then, by limiting physician "assessments" to $500 (the amount of the actuarially inadequate "fees") the Department assured that the hospitals would pay the enormous deficit in the physician malpractice accounts created by the setting of actuarially inadequate physician "fees" at the outset. The uncontroverted facts in this case demonstrate that the Department's application and interpretation of Section 768.54(3), as reflected in the 1977-1978 and 1978-1979 assessments, required hospital members of the Fund to pay for physician malpractice. The subsidy of physician malpractice liability is illustrated in the following chart, which sets forth hospital and physician contributions and obligations to the Fund for 1977-1978 and 1978-1979:

	1977-1978		1978-1979	
	Hospitals	Physicians	Hospitals	Physicians
"Base Fees" & interest already paid	$ 7,070,600	$ 3,134,137	$ 7,353,398	$ 3,150,668
Losses	$ 5,251,416	$ 6,674,774	$ 8,789,510	$14,448,831
Surplus/(Deficit)	$ 1,819,184	($3,540,637)	($1,436,112)	($11,298,163)
Proposed Assessment	$ 1,374,827	$ 1,730,207	$11,480,624	$ 2,411,205
Actual Losses	$ -0-	$ 3,540,637	$ 1,436,112	$11,298,163
Indicated Rate Method	$ 521,560	$ 2,558,372	$ 2,336,924	$11,463,145

As noted above, the Department assessed hospitals approximately $1.4 million for 1977-1978 and $11.5 million for 1978-1979. The chart, however, shows that:

1. For the 1977-78 fund year, hospital fees and interest exceed hospital losses by $1.8 million, and for the 1978-79 fund year, hospital losses exceed hospital fees and interest by $1.4 million. Thus, for these two fund years, hospital fees and interest exceed their losses to date.

2. Physician losses for the same two fund years exceed physician fees and interest by $14.8 million or approximately 236% more than the amount of physician fees and interest.

3. Hospital fees and interest for these two years ($14.4 million) plus the proposed hospital assessments ($12.8 million) total almost twice the amount of hospital losses ($14.0 million). Physician fees and interest ($6.3 million) plus the proposed physician assessments ($4.1 million) total only one-half of the physician losses to date ($21.2 million).

4. Of the $11,480,624 assessment against hospitals for 1978-79, $10,044,512 represents losses attributable to physicians. In other words, 87% of the proposed assessment against hospitals is attributable to physician losses.

5. For the 1977-78 fund year, *all* of the $1.4 million proposed assessment against hospitals is directly attributable to physician losses.

It is important to note that once the physicians "cap out" (pay "assessments" equal to "fees") and the physician losses exceed their fees and interest, all of the physician losses will be assessed against the hospitals. The evidence presented at the hearing showed that the physicians are expected to "cap out" in each of the fund years 1976-77 through and including 1981-82. The estimated physician losses that would be paid by hospitals were estimated at about $140 million.[4]

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4. The most recent report prepared by the Fund indicates that the current best estimate of physician losses to be paid by hospitals is approximately $190 million.

The hearing officer held that notwithstanding the above figures, the assessments were necessary to meet the claims against the Fund, and that the procedure employed by the Department in shifting liability to the hospitals was appropriate *in light of the statutory limit on physician assessments to no more than original fees.* In its Final Order (A40) the Department ruled that the specific statutory requirements of actuarial soundness and that assessments fairly reflect the classifications and that there be separate risk categories for hospitals are "not relevant" in view of the limitation on assessments of physicians.

On appeal to Florida's First District Court of Appeal, appellant hospitals contended, *inter alia,* that:

1. The Department's statutory interpretation was improper. The statute should be read to require that "fees" be actuarially determined and must "fairly reflect the classifications" contemplated by the statute *before* the "assessment" provisions come into play. The statute does not permit the Department to ignore the actuarial "fee" setting procedure and make up the difference through "assessments" which are limited only as to doctors but unlimited as to hospitals. The hospitals argued that the case should be remanded with directions to set "additional fees" so as to have actuarially sound "fees" established *before* there are any "assessments."

2. *If* the statute was properly interpreted and applied by the Department, the statute permits the Department to ignore the concept of actuarial soundness and thus transfer doctor liability to hospitals. Such a statute is not constitutional for several reasons, including:

(a) it violates Federal and State equal protection and due process requirements;

(b) it requires public hospital tax districts to pledge the public credit to subsidize private doctors, which is prohibited by the Florida Constitution; and

(c) it improperly delegates legislative authority to the Executive Branch contrary to the Florida Constitution.

The District Court of Appeal decided that all the constitutional issues were properly raised but that the Federal issues would not be reached because the Florida Constitution's prohibition against delegation of legislative authority rendered the statute unconstitutional:

> "All appellants also challenge the constitutionality of section 768.54(3)(c), both facially and as applied to them, on grounds of unlawful delegation, equal protection, due process and the pledging of public credit for private purposes. Although the hearing officer, correctly, did not pass on these constitutional issues, they are properly before this court for consideration. *See Key Haven Associated Enterprises, Inc. v. Board of Trustees of the Internal Improvement Trust Fund,* 427 So.2d 153 (Fla. 1982). Because we find the issue of unlawful delegation to be dispositive, we do not address the remaining constitutional issues raised. *See Askew v. Cross Key Waterways,* 372 So.2d 913, 918 (Fla. 1978)." 432 So.2d at 594 n. 2.

The Supreme Court of Florida reversed, holding the statute constitutional on its face and as applied and affirming in all respects the assessments set by the Department. The Florida Supreme Court's opinion discussed at length the reasons the District Court of Appeal was wrong on the Florida constitutional issue, and then sum-

marily rejected the Federal constitutional arguments as follows:

> "The appellee hospitals also challenge the statute as violating the equal protection clauses of the Florida and Federal Constitutions. The district court did not address this issue having found the issue of unlawful delegation to be dispositive. Under the equal protection clauses, governmental acts that classify persons arbitrarily may be invalid if they result in treating similar people in a dissimilar manner. *State v. Leicht*, 402 So.2d 1153, 1155 (Fla. 1981), *cert. denied*, 455 U.S. 989, 102 S.Ct. 1611, 71 L.Ed.2d 848 (1982); *State v. Lee*, 356 So.2d 276, 279 (Fla. 1978). Appellants contend that hospitals and physicians are not similarly situated and we agree. While both may fall under a general classification, health care providers, they clearly are not similarly situated. Hospitals are corporate entities with larger budgets and much larger numbers of patients over which to spread costs. There are numerous differences between the two which justify the different treatment of these two groups by the statute. We find no merit to appellees' argument on this issue.
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> "The hospitals have also objected to the statute as violating due process. To comply with the constitutional guarantee of due process of law, all legislative enactments must be rationally related to the achievement of a legitimate legislative purpose. *Rollins v. State*, 354 So.2d 61 (Fla. 1978). The provisions of the statute plainly satisfy the purpose of the statute, namely, to provide medical malpractice protection for Florida health care providers under terms accepted by the participants.
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> • • •

"For these reasons, we upheld the constitutionality of section 768.54(3)(c) and reversed the decision of the district court."

The other related due process and equal protection arguments raised were not specifically discussed.

This appeal timely followed denial of rehearing.

THE QUESTIONS PRESENTED ARE SUBSTANTIAL

1. The statute as interpreted and applied violates the equal protection clause of the Fourteenth Amendment to the United States Constitution.

This Court has stated that where legislation is economic or social in nature, rather than legislation affecting fundamental rights, the Court's equal protection inquiry will be whether the state's discrimination among classes bears (a) a reasonable or rational relationship to the achievement of (b) a valid or legitimate state interest. E.g., *Lindsey v. Normet*, 405 U.S. 56, 92 S.Ct. 862, 31 L.Ed.2d 36 (1972). There is no doubt that the legislation here, as interpreted and applied, does not meet this test. The discrimination and burden imposed by this statutory scheme is different both in quality and degree from recently approved legislation and is analogous to legislation recently disapproved under the "rational basis" test. It is apparent that minimal constitutional requirements have not been met by the Florida statute, as interpreted and applied in the case before the Court.

It must be emphasized that this is not simply a case where one class complains because it is not receiving the *same benefits* from the government that another class

receives.[5] Nor is this a case where one class complains that the government is regulating it, but not regulating a similar class.[6] Instead, this is a case where one class (hospitals) not only does not receive benefits but is asked to pay for the benefits conferred upon another class (physicians). The Florida statute violates "the basic

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5. This Court has specifically recognized governmental *benefits* cases as a separate category of equal protection cases. In *Califano v. Goldfarb*, 430 U.S. 199, 97 S.Ct. 1021, 51 L.Ed.2d 270 (1977), Justice Brennan, citing *Salfi*, *Belcher* and *Dandridge*, *infra* wrote that "Congress has wide latitude to create classifications that allocate noncontractual benefits under a social welfare program." E.g., *Schweiker v. Wilson*, 450 U.S. 221, 101 S.Ct. 1074, 67 L.Ed.2d 186 (1981) (supplemental social security income); *United States R.R. Retirement Board v. Fritz*, 449 U.S. 166, 101 S.Ct. 453, 66 L.Ed.2d 368 (1980) (benefits under Federal Railroad Retirement Act); *Mathews v. de Castro*, 429 U.S. 181, 97 S.Ct. 431, 50 L.Ed.2d 389 (1976) (social security benefits); *Mathews v. Lucas*, 427 U.S. 495, 96 S.Ct. 2755, 49 L.Ed.2d 651 (1976) (surviving child benefits under Social Security Act); *Weinberger v. Salfi*, 422 U.S. 749, 95 S.Ct. 2457, 45 L.Ed.2d 522 (1975) (mother's and children's insurance benefits under Social Security Act); *Geduldig v. Aiello*, 417 U.S. 484, 94 S.Ct. 2485, 41 L.Ed.2d 256 (1974) (state disability insurance program which excluded pregnancy related expenses); *San Antonio Independent School District v. Rodriguez*, 411 U.S. 1, 93 S.Ct. 1278, 36 L.Ed.2d 16 (1973) (governmental financial aid to schools); *Jefferson v. Hackney*, 406 U.S. 535, 92 S.Ct. 1724, 32 L.Ed.2d 285 (1972) (Aid to Families With Dependent Children); *Richardson v. Belcher*, 404 U.S. 78, 92 S.Ct. 254, 30 L.Ed.2d 231 (1971) (social security benefits "offset" for state unemployment compensation); *Dandridge v. Williams*, 397 U.S. 471, 90 S.Ct. 1153, 25 L.Ed.2d 491 (1970) (Aid to Families With Dependent Children).

6. E.g., *Minnesota v. Clover Leaf Creamery Co.*, 449 U.S. 456, 101 S.Ct. 715, 66 L.Ed.2d 659 (1981) (sustaining statute which banned retail sale of milk in plastic containers, but permitted sale in other nonreturnable, nonfillable containers, such as paperboard); *City of New Orleans v. Dukes*, 427 U.S. 297, 96 S.Ct. 2513, 49 L.Ed.2d 511 (1976) (sustaining ordinance that banned street vendors, but "grandfathered" vendors with eight years' continuous service); *Ferguson v. Skrupa*, 372 U.S. 726, 732, 83 S.Ct. 1028, 1032, 10 L.Ed.2d 93 (1963) (sustaining ordinance that exempted attorneys from statutory prohibition on debt adjusting); *Williamson v. Lee Optical Co.*, 348 U.S. 483, 75 S.Ct. 461, 99 L.Ed. 563 (1955) (sustaining statute forbidding opticians from duplicating lenses without a prescription from an ophthalmologist or optometrist); *Railway Express Agency v. New York*,

(Continued on following page)

[equal protection] concept of our system that legal burdens should bear some relationship to individual responsibility or wrongdoing." *New Jersey Welfare Rights Organization v. Cahill*, 411 U.S. 619, 93 S.Ct. 1700, 1701, 36 L.Ed.2d 543 (1973), *quoting Weber v. Aetna Casualty & Surety Co.*, 406 U.S. 164, 175, 92 S.Ct. 1400, 1406, 31 L.Ed. 2d 768 (1972). Accord, *Jimenez v. Weinberger*, 417 U.S. 628, 94 S.Ct. 2496, 2499, 41 L.Ed.2d 363 (1974). As one state court has rightly noted, "[a]t one time or another every type of profession or business undergoes difficult times, and it is not the business of government to manipulate the law so as to provide succor to one class . . . by depriving another . . . of the equal protection mandated by the constitution." *American Bank & Trust Co. v. Community Hospital of Los Gatos-Saratoga, Inc.*, 104 Cal. App. 3d 219, 163 Cal. Rptr. 518, 520 (1980), *superseded*, 33 Cal. 3d 674, 190 Cal. Rptr. 371, 660 P.2d 829 (1983).

In the case of *Schweiker v. Wilson*, 450 U.S. 221, 101 S.Ct. 1074, 67 L.Ed.2d 185 (1981), this Court in a five to four decision determined that there was a rational basis for a congressional decision not to extend certain social security benefits to a class of persons in public mental institutions. The majority of the Court found a rational basis for the congressional decision drawing the line beyond which the minor benefits in that case would not be extended. The case on appeal is different. Appellants submit that the *Schweiker* court would have found

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Footnote continued—

336 U.S. 106, 69 S.Ct. 463, 93 L.Ed. 533 (1949) (sustaining ordinance banning only certain vehicles from advertising); *Miller v. Strahl*, 239 U.S. 426, 36 S.Ct. 147, 60 L.Ed. 364 (1915) (sustaining statute requiring hotelkeepers with at least 50 rooms to take certain fire precautions); *Engel v. O'Malley*, 219 U.S. 128, 130, 31 S.Ct. 190, 193, 55 L.Ed. 128 (1911) (sustaining exemption of businesses in which average sum received for safekeeping or transmission was more than $500 from licensing requirements designed to protect small depositors).

the legislation unconstitutional if Congress had not only refused to extend the benefits to the inmates of public mental hospitals but had additionally required the inmates in public mental hospitals to pay for the benefits actually conferred upon others! It is one thing to refuse to extend benefits beyond a certain point by defining a class to which benefits will extend; it is quite another thing for the State to impose upon the disfavored class the burden of paying the legal liabilities of the favored class, especially when the class upon which the burden is imposed has no control over the amount of the exposure.

This Court recently held in *Plyler v. Doe*, 457 U.S. 202, 102 S.Ct. 2382, 72 L.Ed.2d 786 (1982) that while the state had a legitimate purpose in discouraging illegal aliens, there was no *rational* relationship between that state interest and a statute denying education to the children of such illegal aliens. The Court emphasized that while denying benefits to the children of offenders might make it less attractive for aliens illegally to enter this country, the legislative remedy of visiting the sins of the fathers on their children was so extreme and unjust as to not meet the test of *rational* relationship. To analogize, it may be true as suggested by appellees below that giving doctors virtually free malpractice coverage will make their practices more lucrative and therefore encourage doctors to practice in Florida; but the decision by the State to achieve that end at the exclusive expense of another group of citizens - hospitals and their patients - is so unfair and unjust as to be irrational.

This case is also analogous to another equal protection case recently decided by this Court. In *Zobel v. Williams*, 457 U.S. 55, 102 S.Ct. 2309, 72 L.Ed.2d 672 (1982), the Court struck down Alaska's statute allocating its mineral resource revenues among its citizens depending

on their lengths of residency. The Court held the statute did not meet the "rational relationship" test applicable to such economic discrimination. The suggested justification for the Alaska statute was that it would encourage people to become and remain residents of Alaska. In this case, a similar justification was suggested below by the appellees that the statute would encourage doctors to move to and remain in Florida. The *rational* relationship is here likewise lacking. When in this case the factor is added that not only are hospitals not benefited as are physicians, but also they are made to subsidize the discriminatory benefits to physicians, the *Zobel* case becomes an *a fortiori* holding that the current legislation as interpreted and applied violates the hospitals' rights to equal protection.

That the classification here does not bear a fair and substantial relation to the legislative purpose appears even more clearly when the *stated* legislative purpose is examined. E.g., *Califano v. Goldfarb*, 430 U.S. 199, 97 S.Ct. 1021, 1030, 51 L.Ed.2d 270 (1977); *Kuhn v. Vergiels*, 558 F.Supp. 24 (D. Nev. 1982). The legislative purpose stated in the preamble to the original Florida act was to alleviate a crisis in the availability of medical malpractice insurance to *all* health care providers, not just doctors:

> Whereas, the cost of purchasing medical professional liability insurance for doctors *and other health care providers* has skyrocketed in the past few months; . . . and whereas, the consumer ultimately must bear financial burdens created by the high cost of insurance; . . . and whereas, the problem has reached crisis proportion in Florida. . . .

Chapter 75-9, Laws of Florida (1975) (emphasis added) (A87).

It is clear from the cases that the "rational relationship" test means more than "logically connected." The "rationality" requirement also precludes an unfair or unreasonable approach to the legitimate end. As this Court noted in *Bolling v. Sharpe*, 347 U.S. 497, 74 S.Ct. 693, 98 L.Ed. 884 (1955), equal protection stems from the American ideal of fairness. In *Gomez v. Perez*, 409 U.S. 535, 93 S.Ct. 872, 35 L.Ed.2d 56 (1973), this Court struck down on equal protection grounds Texas laws requiring a father to support legitimate but not illegitimate children, holding that the Texas laws were "illogical and unjust".[7] Even though a policy of discriminating against an illegal alien's children may make him think twice about illegally entering the country, that legislative scheme is not *rationally* related to the legitimate end. *Plyler v. Doe, supra.*

The Supreme Court of Florida, in summarily rejecting the hospitals' equal protection claims, noted that hospitals and physicians "are not similarly situated. Hospitals are corporate entities with larger budgets and much larger numbers of patients over which to spread costs. There are numerous differences between the two which justify the different treatment. . . ." Of course, there *are* differences between hospitals and physicians - constitutionally, however, those differences are insufficient to require the hospitals to fund 90% of the physicians' malpractice liability. That hospitals are bigger than doctors or that they

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7. In the case of *Jimenez v. Weinberger*, 417 U.S. 628, 94 S.Ct. 2496, 41 L.Ed.2d 363 (1974), this Court held the equal protection clause invalidated a social security provision limiting disability benefits to those illegitimate children whom the wage earner had supported prior to his disability. The Court found the classification not justified by any legitimate interest. The Court recognized that the prevention of spurious claims is a legitimate governmental interest but "[i]t does not follow . . . that the blanket and conclusive exclusion of appellants' subclass of illegitimates is reasonably related to the prevention of spurious claims . . ." 94 S.Ct. at 2501.

usually are corporations does not eliminate constitutional protection. *See, e.g., Prudential Health Care Plan v. Commissioner of Insurance,* 626 S.W.2d 822, 831-32 (Tex. Civ. App. 1981) (imposing increased regulatory fees on corporation violates equal protection).

The Department also suggested below that the discrimination against hospitals was constitutional because "[h]ospitals are basically stationary entities and do not move around [and p]hysicians, on the other hand, are much freer to leave the state and go to practice in another area." [Department of Insurance Br. at 43]. It is plainly no justification for discrimination that the disfavored class cannot do anything about it. The Seventh Circuit Court of Appeals found Chicago's practice of paying small tort judgments immediately but deliberately delaying payment of larger ones not "rationally related" to a legitimate end, even if it might tend to accomplish that end. The Seventh Circuit held that while the City's practice might encourage judgment creditors to settle for less and effect the legitimate end of reducing litigation costs, there was no "rational basis" because the City cannot legitimately "exploit the willingness of those adversely affected by an arbitrary classification to sacrifice part of their claims in order to escape the undue delay the City imposes upon the class it disfavors . . ." *Evans v. City of Chicago,* 689 F.2d 1286, 1299-1300 (7th Cir. 1982).

Both physicians and hospitals fall within the statutory category of "health care providers" (Section 768.54(1)(b)) (A76) and, as such, are "similarly situated." The statute, as interpreted and applied to require hospitals to pay physician malpractice liability, arbitrarily distinguishes between the two classifications. *See, e.g., Lindsey v. Normet,* 405 U.S. 56, 92 S.Ct. 862, 31 L.Ed.2d 36 (1972), where this Court held that a statute requiring tenant

appellants in forcible entry and wrongful detainer [FED] actions to post a bond in *twice* the amount of the rent violated equal protection where no other appellants were required to post a "double bond." This Court wrote that the "double bond" had "no reasonable relationship to any valid state objective" and "arbitrarily discriminate[d] against tenants appealing from adverse decisions in FED actions."

Plainly, the statute violates the hospitals' right to equal protection of the laws.

2. Substantive due process requires that a statute be reasonably related to the legislative goal and prohibits confiscatory legislation.

The two aspects of substantive due process violated here are the prohibition against confiscatory state action and the prohibition against arbitrary or irrational legislation.

Due process prohibits arbitrary or unreasonable governmental interference with life, liberty or property interests, without a rational relationship to a legitimate governmental purpose. *Exxon Corp. v. Governor of Maryland*, 437 U.S. 117, 98 S.Ct. 2207, 57 L.Ed.2d 91 (1978); *Wolff v. McDonnell*, 418 U.S. 539, 94 S.Ct. 2963, 41 L.Ed.2d 935 (1974).

As previously discussed, the statute under consideration purported to be a legislative attempt to reduce the cost of medical malpractice insurance to all health care providers, not just physicians. In the statute, as interpreted and applied, due process is present only if placing the burden of physician malpractice on hospitals is rationally related to the goal of lower medical malpractice insurance cost for health care providers in general, in-

cluding hospitals, and their patients. Obviously it is not. Rather, the statute as interpreted and applied improperly shifts the burden of such costs from one group supposed to be protected by the statute to another group which should be equally protected by the statute.

The second feature of this case important to the due process analysis is the confiscatory effect of the legislation on the appellants. Admittedly, other cases in this Court and in lower federal and state courts have upheld legislation affecting insurance and malpractice. However, *all* those cases emphasize either that there was no unreasonable shifting of a burden from one identifiable group to another or that any such shifting could be recouped from the state treasury or through appropriate premiums, so that there is no confiscatory effect. For example, in *California State Automobile Ass'n Inter-Insurance Bureau v. Maloney*, 341 U.S. 105, 71 S.Ct. 601, 95 L.Ed. 788 (1951) California's compulsory assigned risk statute required insurance companies to join a plan to insure automobile drivers not otherwise able to obtain insurance. In finding that the statute did not violate the insurance companies' due process rights, the Court emphasized that, although the insurer was required to accept business it would not otherwise elect to write, (a) it could protect itself by charging *premiums commensurate* with the greater risk of the new business;[8] (b) there was an equitable apportionment of the assigned risks

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8. Statutes requiring insurance companies to offer certain coverage have been sustained against constitutional challenges where the insurance company may charge increased premiums commensurate with the risk. E.g., *Reserve Life Ins. Co. v. LaFollette*, 108 Wis. 2d 637, 323 N.W.2d 173 (Wis. Ct. App. 1982); *Century Cab, Inc. v. Commissioner of Insurance*, 327 Mass. 652, 100 N.E.2d 481, 488 (1951) ("[n]o contention is made that the premium changes . . . . are not adequate to produce enough revenue to the insurance companies to pay all losses and allow a reasonable profit").

among all insurers; (c) *uninsurable risks* were eliminated from the plan; (d) a *limited liability* policy of $5000-$10,000 was all that was required, so the risk was limited; and (e) the appellant was *not* required to "serve all comers." The Court described these as "important restrictions on the financial commitments incident to the broadened undertaking." 341 U.S. at 108, 109, 71 S.Ct. at 603.

The contrast with this case is apparent. In this case no doctor may be refused insurance by the Fund regardless of the fact that he may be otherwise uninsurable. The hospital members thus subsidize both the uninsurable risks and those who could obtain other insurance. Further, while there was limited exposure to the insurer in the California case, here the liability of the hospitals for the doctor malpractice is unlimited.

Also, contrary to some of the "rational justification" arguments below the hospitals have no way to limit their exposure through proper risk management. Although theoretically (but not practically) hospitals can exclude incompetent physicians from their staffs, the hospitals are required here to pay physician malpractice liability for all doctor members of the fund, whether excluded from staff or not. Hospitals can manage risks to the extent of having no claims whatever against them or their staff but still be required under the statute to pay millions of dollars to subsidize physician malpractice liability. There simply is no rational basis for the legislation, as interpreted and applied.

In addition, the hospitals here have no ability to limit their liability or to charge the doctors a premium commensurate with the risks. Although a cursory reading of the statute would indicate that the Insurance Commissioner's job was to charge doctors actuarially indicated

fees (thus fees commensurate with the risks) the Supreme Court of Florida in the decision appealed has instead endorsed the Insurance Commissioner's arbitrary selection of a minimal fee for doctors resulting in the shift of doctor malpractice liability to hospitals. This interpretation and application contravenes the Constitution and requires reversal.

The legislation here, for similar reasons, may be contrasted with the legislation in *Insurers' Action Council, Inc. v. Markman*, 490 F.Supp. 921 (D. Minn. 1980), *aff'd*, 653 F.2d 344 (8th Cir. 1981), where the Eighth United States Court of Appeals adopted the trial court's opinion in sustaining Minnesota legislation requiring accident and health insurers to participate in a pool to provide major medical coverage for persons not ordinarily insurable. In rejecting due process and equal protection challenges, the court pointed out that the statute contained a provision that permitted losses suffered by members of the pool to be passed on to the State of Minnesota through credits against Minnesota's insurance premium tax and income tax. In rejecting the due process challenge, the court noted that "The legislative classification is therefore simply a means to pass the cost of insuring the uninsurable to the taxpayer without levying a direct tax, and as such is rationally related to a legitimate state interest." 490 F.Supp. at 927. Thus, in that case the financial exposure from the requirement for members of the pool to provide limited coverage was recouped through a credit against state taxes. There is no comparable provision here. There is no case upholding discriminatory legislation requiring one group to bear the financial burdens of another.

The confiscatory effect of this legislation is apparent when it is considered that, in general, the only source of revenue for the hospitals to pay the enormous increase

in operating costs caused by requiring them to assume physician malpractice liability is to increase hospital charges to patients. The testimony gives examples of some of the reasons that demonstrate that this is an unrealistic prospect, however, particularly for those hospitals which serve charity patients in whole or in part. If collected in one year, the malpractice costs increase may reach $15,000 per bed for paying patients, since charity patients cannot be expected to bear their share. On a 300 day occupancy rate, that translates to $50.00 per day increase in hospital charges or expenses. Although hospitals were required to join the Fund unless they had other insurance (and although the "medical malpractice insurance crisis" was precipitated by the unavailability of commercial medical malpractice insurance), there are large chains of hospitals who had their own captive insurance companies and were not members of the Fund. Accordingly, those companies are not saddled with the $50.00 per day increase caused by the physician malpractice subsidy. Where such hospitals compete, it is unrealistic to assume that member hospitals can recoup these costs even if the transfer of the cost of physician malpractice to hospital patients did cure the constitutional defects. Bankruptcies may be predicted, and since an unpaid assessment by one hospital automatically increases the deficit and requires additional hospital assessments, a domino effect becomes obvious. The result is constitutionally intolerable.

Patients' Compensation Funds in Other Jurisdictions

Bearing on the importance of the issues before the Court is the treatment of Patients' Compensation Funds in other jurisdictions. The New Hampshire Supreme Court has noted that, while controlling malpractice premiums is a worthwhile object, the legislature cannot accomplish

that object by placing the burden on an innocent class. *Carson v. Maurer*, 120 N.H. 925, 424 A.2d 825, 836-837 (1980). Similarly, California courts invalidated certain legislative responses to the malpractice crisis as denying equal protection because it was constitutionally impermissible to impose the costs of the legislation on one class. *American Bank & Trust Co. v. Community Hospital of Los Gatos-Saratoga, Inc.*, 104 Cal. App. 3d 219, 163 Cal. Rptr. 513, 520 (1980), *superseded*, 33 Cal. 3d 674, 660 P.2d 829, 190 Cal. Rptr. 829 (1983). As the California court noted,

> "it defies reason why, although the general population purportedly derives the benefits of eliminating the potential windfall from lump-sum judgments, only the victims of medical malpractice must be penalized. Moreover, even if we assume that it is reasonable to burden the medical malpractice victim so that medical malpractice insurance premiums may be lowered, it is incomprehensible why only those victims whose future damages exceed $50,000 are singled out. We can only conclude that the Legislature has taxed an impermissible special class for the purported benefits to be enjoyed by the general public." 163 Cal. Rptr. at 521.

In *McCoy v. Commonwealth*, 37 Pa. Commw. 530, 391 A.2d 723 (1978), the Pennsylvania Commonwealth Court sustained a patient's compensation fund, noting that contributions to the Fund "roughly relate to the degree of risk," 391 A.2d at 727. The court held that there was no improper classification "[a]bsent a factual showing that physicians, hospitals and nursing homes bore the cost of professional liability insurance when in fact the risk involved, as shown by actual claims, involve health care providers other than this class." 391 A.2d at 729. Clearly

implicit in that holding was the proposition that if a certain class is required to bear the malpractice losses of another class, there would be a denial of equal protection. Similarly, the Kentucky Supreme Court, in sustaining actuarially based assessments against health care providers, noted that "we do not mean to suggest . . . that the members of any profession or business could be validly requested to undertake the responsibility of providing for the payment of all malpractice judgments rendered against any of them." *McGuffy v. Hall*, 557 S.W.2d 401, 416 (Ky. 1977).

Other states have patient compensation funds,[9] financed in various ways. Florida's apparent "solution" to the cost of physician malpractice should be reviewed by the Court.

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9. E.g., Colorado, Hawaii, Illinois, Indiana, Kansas, Kentucky, Louisiana, Nebraska, New Mexico, Puerto Rico, North Dakota, Oregon, Pennsylvania, South Carolina and Wisconsin. See Note, *Patient Compensation Funds; Legislative Responses to the Medical Malpractice Crisis*, 5 Am. J. Law & Med. 175 (1980).

CONCLUSION

For the foregoing reasons, the Court should note probable jurisdiction.

Respectfully submitted,

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APPENDIX

LIST OF PARTIES AND RELATED COMPANIES

Appellants

Abbey Foundation, Inc.

Alachua General Hospital, Inc.
Parent: Santa Fe Healthcare Systems, Inc.

American Hospital

Anclote Psychiatric Center, Inc.

Baptist Hospital of Miami, Inc.

Bartow Memorial Hospital

Bayfront Medical Center

Bay Medical Center

Board of County Commissioners of Pasco County d/b/a Jackson Memorial Hospital
Parent holding company: Adventist Health Systems Sunbelt Health Care Corporation, 2400 Bedford Road, Orlando, Florida 32803

Bradford Hospital Corporation
Direct Parent: Genesis Hospital System, Inc.
Overall Parent: Santa Fe Health Care Systems, Inc.
Affiliates: Calhoun Hospital, Inc.
Alachua General Hospital, Inc.
Williston Memorial Hospital, Inc.
North Central Florida Hospice, Inc.

Brevard Hospital Association, Inc. d/b/a James E. Holmes Regional Medical Center
Affiliates: Brevard Health Services, Inc.
Brevard Management, Inc.
Melbourne Regional Properties, Inc.

Calhoun Hospital
Direct Parent: Genesis Hospital System, Inc.
Overall Parent: Santa Fe Health Care Systems, Inc.
Affiliates: Bradford Hospital Corporation
Alachua General Hospital, Inc.
Williston Memorial Hospital, Inc.
North Central Florida Hospice, Inc.

Campbellton-Graceville Hospital Corporation

Cedars Medical Center, Inc.

Centro Asturiano Hospital

Charlotte Community Hospital, Inc. d/b/a Fawcett Memorial Hospital
Parent: Basic American Medical, Inc.

Doctors Hospital, Inc. of Plantation d/b/a Doctors General Hospital

Doctors Memorial Hospital Perry, Florida

East Coast Hospital, Inc.

Eugene Wuesthoff Memorial Hospital Association, Inc.

Fisherman's Hospital, Inc.

Flagler Hospital, Inc.

Fort Myers Community Hospital, Inc.
Parent: Basic American Medical, Inc.

Gadsden Memorial Hospital

Gateway Hospital Corporation Liquidating Trust

Geriatrics Service Complex Foundation, Inc. d/b/a South Shore Hospital & Medical Center

Glades General Hospital

Good Samaritan Hospital Association, Inc.

Heart of Florida Hospital Association, Inc.

Hialeah Hospital, Inc.
Affiliates: Corona Community Hospital, Corona, California
Tidewater Memorial Hospital, Tappahannock, Virginia

Highlands County Hospital Tax District Authority

Hollywood Medical Center, Inc.

Holy Cross Hospital, Inc.
Affiliate: Sisters of Mercy of the County of Allegheny

Jacksonville General Hospital

John F. Kennedy Memorial Hospital, Inc.

Kissimmee Memorial Hospital, Inc.
Parent: Basic American Medical, Inc.

Lake Community Hospital
Parent: U. S. Health Corporation

Lake Wales Hospital Association, Inc.

Larkin General Hospital, Inc.

Lee Memorial Hospital
Affiliates: Estero MedCenter
Miner's Corner MedCenter

Leesburg Hospital Association

LeHigh Acres General Hospital, Inc.

Lykes Memorial Hospital, Inc.

Manatee County, Florida (Operating Manatee Memorial Hospital)

Martin Memorial Hospital
Parent: Coastal Health Corporation
Affiliates: Martin Memorial Foundation, Inc.
Coastal Care Corporation
Medical and Financial Management, Inc.

Mercy Hospital, Inc.
Affiliate: Mercy Hospital Foundation, Inc.

Metropolitan General Hospital
Subsidiary: Metropolitan Medical Arts Services, Inc.

Miami Heart Institute

Morrow Memorial Hospital
Parent: Bishop John Grady, Bishop of Catholic Diocese of Orlando

Morton F. Plant Hospital Association, Inc.

North Miami General Hospital, Inc.

Northridge General Hospital

Orlando General Hospital, Inc.

Orlando Regional Medical Center
Parent: Orlando Health Network, Inc.
Affiliates: Orlando Regional Medical Center, Inc.
Healthnet Services, Inc.

Ormond Beach Memorial Hospital

Palm Beach Martin County

Palm Springs General Hospital
Affiliate: Brusa, Inc.

Pan American Hospital Corp.

Pembroke Pines General Hospital
Parent: U. S. Health Corp.

Riverside Hospital
Parent: RiverGroup, Inc.
Affiliates: River Corporation, Inc.
Riverside Foundation

St. Cloud Hospital, Inc.

St. Francis Hospital, Inc.

St. Joseph's Hospital, Inc.

St. Joseph Hospital of Port Charlotte
Parent: The Felician Sisters

St. Mary's Hospital, Inc.
Parent: St. Mary's Medical Center, Inc.
Affiliate: St. Mary's Hospital Foundation, Inc.

St. Petersburg Osteopathic

Seminole Memorial County Hospital (Purchased 3/4/80 by Central Florida Regional Hospital, Inc.)
Parent: Hospital Corporation of America

South Broward Hospital District d/b/a Memorial Hospital

South Florida Baptist Hospital

South Sarasota County Memorial Hospital d/b/a Venice Hospital
Parent: Gulf Area Medical Properties, Inc.

Southeastern Palm Beach County Hospital District d/b/a Bethesda Memorial Hospital

Sun Coast Osteopathic Hospital, Inc.
Affiliate: Sun Coast Shopping Center, Inc.

Tallahassee Memorial Regional Medical Center, Inc.
Subsidiary: Southeast Community Health Services

Tarpon Springs Hospital Foundation, Inc.

The Fish Memorial Hospital

Trustees of Mease Hospital, Inc. d/b/a Mease Hospital

University Community Hospital

Waterman Memorial Hospital Association, Inc.
Parent: Lake County Health Care Systems Co., Inc.

Winter Haven Hospital, Inc.
Parent: Mid Florida Medical Services, Inc.
Affiliates: Mid Florida Home Health Services, Inc.
Winter Haven Hospital Development Foundation, Inc.

Winter Park Memorial

Appellees

Department of Insurance, State of Florida

Florida Patient's Compensation Fund

ORDER OF JUNE 9, 1983

DEPARTMENT OF INSURANCE, STATE OF FLORIDA, et al.,
Appellants,

v.

SOUTHEAST VOLUSIA HOSPITAL DISTRICT, et al.,
Appellees.

FLORIDA PATIENT'S COMPENSATION FUND, et al.,
Appellants,

v.

SOUTHEAST VOLUSIA HOSPITAL DISTRICT, et al.,
Appellees.

Supreme Court of Florida.

Case Nos. 63,698, 63,699 & 63,751.

June 9, 1983. Three Consolidated Appeals from the District Court of Appeal, First District - Constitutional Invalidity.

(PER CURIAM.) This cause is before this Court on an expedited appeal from a decision of the First District Court of Appeal in Southeast Volusia Hospital District v. State of Florida, Department of Insurance, Cases numbered AN-412, AN-367 (May 17, 1983), which declared section 768.54(3)(c), Florida Statutes (1981), creating the Florida Patient's Compensation Fund, unconstitutional. This decision by the First District Court of Appeal has created uncertainty and confusion regarding issues of great public importance which require immediate resolution.

We hold that the statute is constitutional on its face and as applied; therefore, the decision of the district court is quashed.

An opinion explaining our rationale and discussing other issues will be filed at a later date.

It is ordered. (Alderman, C.J., Adkins, Boyd, Overton, McDonald, Ehrlich and Shaw, JJ., Concur.)

OPINION AND JUDGMENT OF SEPTEMBER 15, 1983

DEPARTMENT OF INSURANCE, State of Florida, et al., Appellants,

v.

SOUTHEAST VOLUSIA HOSPITAL DISTRICT, et al., Appellees.

FLORIDA PATIENT'S COMPENSATION FUND, et al., Appellants,

v.

SOUTHEAST VOLUSIA HOSPITAL DISTRICT, et al., Appellees.

Nos. 64698, 63699 and 63751.

Supreme Court of Florida.

Sept. 15, 1983.

Rehearing Denied Nov. 4, 1983.

ADKINS, Justice.

This cause is before this Court on a direct appeal from a decision of the First District Court of Appeal in *Southeast Volusia Hospital District v. State of Florida, Department of Insurance*, 432 So.2d 592 (Fla. 1st DCA 1983), which declared section 768-54(3)(c), Florida Statutes (1981), unconstitutional. We have jurisdiction. Art. V, § 3(b)(1), Fla. Const.

Appellants are the Florida Patient's Compensation Fund (Fund) and the Department of Insurance (Department). Appellees are fifty-seven Florida hospitals who were members of the Fund during either Fund year 1977-78, 1978-79, or both. Section 768.54 created the Florida Patient's Compensation Fund. Section 768.54(3)(c) specifies the terms of the Fund's contracts with its members. The Fund, which commenced operation in 1975, is a non-profit entity which provides medical malpractice protection to the physicians and hospitals who join it. The act creating the Fund permits all health care providers, other than hospitals, to become members if they choose to, but hospitals are required to join unless they can demonstrate financial responsibility for malpractice claims. The Fund is financed through base fees paid by its members, additional fees, and assessments.

Section 768.54(3)(c) reads:

> (c) Fees and assessments.—Annually, each health care provider, as set forth in subsection (2), electing to comply with paragraph (2)(b) shall pay the fees established under this act, for deposit into the fund, which shall be remitted for deposit in a manner prescribed by the Insurance Commissioner. The limitation of liability provided by the fund shall begin July 1, 1975, and run thereafter on a fiscal-year basis. For the first year of membership, each participating health care provider shall pay a base fee for deposit into the fund in the amount of $1,000 for any individual, or $300 per bed for any hospital. Those entering the fund after the fiscal year has begun shall pay a prorated share of the yearly fees for a prorated membership. The base fee charged after the first year of participation shall be $500 for any individual, or $300 per bed for any hospital. The base fees to be paid by

those health care providers defined in subparagraphs (1)(b)5., 6., 7., and 8. shall be established by the fund on an actuarially sound basis. In addition, after the first year of operation, additional fees may be charged but shall be appropriately prorated for the portion of the year for which the health care provider participated in the fund, based on the following considerations:

1. Past and prospective loss and expense experience in different types of practice and in different geographical areas within the state;

2. The prior claims experience of the members covered under the fund; and

3. Risk factors for persons who are retired, semi-retired, or part-time professionals.

Such base fees may be adjusted downward for any fiscal year in which a lesser amount would be adequate and in which the additional fee would not be necessary to maintain the solvency of the fund. Such additional fee shall be based on not more than two geographical areas with three categories of practice and with categories which contemplate separate risk ratings for hospitals, for health maintenance organizations, for ambulatory surgical facilities, and for other medical facilities. Each fiscal year of the fund shall operate independently of preceding fiscal years. Participants shall only be liable for assessments for claims from years during which they were members of the fund; in cases in which a participant is a member of the fund for less than the total fiscal year, a member shall be subject to assessments for that year on a pro rata basis determined by the percentage of participation for the year. The fund shall be maintained at not

more than $15,000,000 per fiscal year. Additional fees, assessments, or refunds shall be set by the Insurance Commissioner after consultation with the board of governors of the fund. Nothing contained herein shall be construed as imposing liability for payment of any part of a fund deficit on the Joint Underwriting Association authorized by s. 627.351(7) or its member insurers. If the fund determines that the amount of money in an account for a given fiscal year is in excess of or not sufficient to satisfy the claims made against the account, the fund shall certify the amount of the projected excess or insufficiency to the Insurance Commissioner and request the Insurance Commissioner to levy an assessment against or refund to all participants in the fund for that fiscal year, prorated, based on the number of days of participation during the year in question. The Insurance Commissioner shall order such refund to, or levy such assessment against, such participants in amounts that fairly reflect the classifications prescribed above and are sufficient to obtain the money necessary to meet all claims for said fiscal year. In no case shall any assessment for a particular year against any health care provider, other than those health care providers defined in subparagraphs (1)(b) 1., 5., 6., and 7., exceed an amount equal to the fees originally paid by such health care provider for participation in the fund for the year giving rise to such assessment. If any assessments are levied in accordance with this subsection as a result of claims in excess of the limitation of a provider's liability of $500,000 per occurrence as specified in paragraph (2)(b), and such assessments are a result of the liability of certain individuals and entities specified in paragraph (2)(e), only hospitals shall be subject to such assessments.

In October of 1981, the Fund certified to the Department deficiencies for the Fund years 1977-78 and 1978-79 totalling some $17 million and sought an assessment against Fund members. A hearing officer found the assessments necessary. The Department levied these assessments against the Fund participants to meet the deficiencies. The Department interpreted section 768.54(3)(c) as precluding assessments against health care providers, other than hospitals, which would exceed the amount of fees paid by those individuals for participation in the Fund for the year found to be deficient. As a result, $10.5 million in additional assessments for claims stemming from charges of physician malpractice were assessed against the hospitals (also HMO's ambulatory surgical centers, and other medical facilities participating in the Fund).

Appellee hospitals filed an appeal to the First District Court of Appeal arguing: 1) that section 768.54(3)(c) did not require the assessments against the hospitals as ordered; 2) that the order was not supported by substantial evidence; and 3) that the statute was unconstitutional. The district court held that the statute was an unlawful delegation of legislative power because it lacked sufficient standards and guidelines to the Department for its proper administration of the Fund.

The Fund and the Department immediately filed this appeal and a motion for expedited review to this Court. The motion was granted. On June 9, 1983, we issued an order, after hearing the oral arguments in this case, declaring the statute to be constitutional both on its face and as applied. *Department of Insurance v. Southeast Volusia Hospital District*, 432 So.2d 592 (Fla. 1983). Accordingly, the decision of the district court was reversed. We stated at that time that this opinion would follow.

The district court found the statute to be almost totally absent of guidelines and standards for the establishment of fees and assessments. The opinion cited six provisions which were deemed invalid for giving "sole discretion" to the Fund in the absence of sufficient guidelines. The first provision held to be constitutionally infirm is the provision which directs that base fees for health maintenance organizations, ambulatory surgical centers and other medical facilities (as defined by § 768.54(1)(c)) are to be "established by the fund on an actuarially sound basis." The district court stated that this part of the statute left to the Fund sole discretion for establishing the amount of fees. We do not agree. We do agree with the district court's conclusion that the crucial test in determining whether a statute amounts to an unlawful delegation of legislative power is whether the statute contains sufficient standards or guidelines to enable the agency and the courts to determine whether the agency is carrying out the legislature's intent. *Askew v. Cross Key Waterways*, 372 So.2d 913 (Fla.1978); *Lewis v. Bank of Pasco County*, 346 So.2d 53 (Fla.1976). The courts of Florida have found concepts of actuarial soundness to be a meaningful standard. *McNulty v. Blackburn*, 42 So.2d 445, 447 (Fla.1949). The Florida Constitution employs the standard of "sound actuarial basis." Art. X, § 14, Fla. Const. These principles are also incorporated in other statutes. §§ 627.062(2)(a) & 627.0651(2), Fla.Stat. (Supp.1982). There is simply no merit to this argument.

The second provision found invalid by the lower court is that which provides that base fees in general may be "adjusted downward" for any fiscal year in which a "lesser amount would be adequate." We do not find this criterion to be vague or standardless. Providing a clearly defined and limited option to the Fund to make such adjustments when additional fees are not necessary to maintain the

solvency of the Fund is not an example of an improper delegation of legislative power. *The Tribune Co. v. School Board of Hillsborough County*, 367 So.2d 627, 628 (Fla. 1979).

The district court also found the statute deficient for failing to state expressly how or when additional fees are to be set and whether they are a prerequisite to the levying of assessments. The statute does set forth explicit factors which are to be applied in setting additional fees. The statute does not unconstitutionally delegate legislative power simply because it leaves the determination of when these fees will be set up to the Department. The legislature may delegate to authorized officials and agencies the authority to determine facts to which the established policies of the legislature are to apply. *Florida Welding & Erection Service, Inc. v. American Mutual Insurance Co.*, 285 So.2d 386, 388 (Fla.1973). It is the power to say *what* the law is that is prohibited from being delegated. *Coca-Cola Co., Food Division v. State, Department of Citrus*, 406 So.2d 1079 (Fla.1981), *appeal dismissed sub nom Kraft, Inc. v. Florida Department of Citrus*, 456 U.S. 1002, 102 S.Ct. 2288, 73 L.Ed.2d 1297 (1982); *Rosslow v. State*, 401 So.2d 1107 (Fla.1981).

The fifth area of the statute attacked by the district court for an obvious absence of standards and guidelines is the portion of section 768.54(3)(c) which deals with assessments. The court found that those provisions give "total discretion" to the Fund "to determine whether the monies collected in a given fund year are in excess or insufficient to satisfy claims made against the fund year" without supplying any guidance to assist the Fund in this determination. Again, we find no merit in the proposition that this constitutes the sort of delegation which is a non-delegable legislative function. The question of determin-

ing when a deficit exists or not is a technical issue of implementation and not a fundamental policy decision. To require constant legislative supervision of the question of when a deficit exists or the selection from the numerous available tests that might be used for that purpose is neither practical nor required by the constitution. *Cf. State v. Bender*, 382 So.2d 697 (Fla.1980) (Court approved statutory provisions directing the Department of Highway Safety & Motor Vehicles and the Department of Health & Rehabilitative Services to establish and approve appropriate testing methods for determining alcohol intoxication).

Finally, the district court found fault with the statute's provisions for levying assessments. The court found the statutory standard for levying assessments ambiguous and a delegation problem because different interpretations of this language were offered by the Fund and the hospitals. This finding is contrary to well established principles of law. A statute is not unconstitutional simply because it is subject to differing interpretations. The administrative construction of a statute by the agency charged with its administration is entitled to great weight. We will not overturn an agency's interpretation unless clearly erroneous. *State ex rel. Biscayne Kennel Club v. Board of Business Regulation*, 276 So.2d 823, 828 (Fla.1973). In addition, when an interpretation upholding the constitutionality of a statute is available to this Court, we must adopt that construction. *Miami Dolphins, Ltd. v. Metropolitan Dade County*, 394 So.2d 981, 988 (Fla.1981); *Leeman v. State*, 357 So.2d 703, 705 (Fla.1978).

The statute requires the Insurance Commissioner to levy assessments against fund members in amounts which "fairly reflect the classifications prescribed above." The Fund and the Department interpret this part of the statute

as requiring assessments to be fairly related to the same criteria that are utilized for setting the original fees. The Department has followed precisely this approach in levying the assessments being contested in this appeal. The details of this approach were developed by the Department's actuary. The hearing officer found that this method fairly reflected the assessments to the classifications prescribed in the statute. The method utilized involves modification to allow for the statute's proscription against assessing health care providers more than "an amount equal to the fees originally paid by such health care provider for participation in the fund for the year giving rise to such assessments." The Department and the Fund contend that this statutory cap places a total cumulative limit on how much a physician can be assessed for a particular fund year, the cap being equal to one hundred percent of the member's fees originally paid for the *fund year giving rise to the assessment*. Appellee hospitals contend that the statute should be read as allowing each member to be assessed one hundred percent of his fees *each* year that passes after the fund year for which the assessment is being levied. The Department's construction of the statutes is clearly based upon a plain reading of the statute and we uphold that interpretation.

The appellee hospitals also challenge the statute as violating the equal protection clauses of the Florida and Federal Constitutions. The district court did not address this issue having found the issue of unlawful delegation to be dispositive. Under the equal protection clauses, governmental acts that classify persons arbitrarily may be invalid if they result in treating similar people in a dissimilar manner. *State v. Leicht*, 402 So.2d 1153, 1155 (Fla. 1981), *cert. denied*, 455 U.S. 989, 102 S.Ct. 1611, 71 L.Ed.2d 848 (1982); *State v. Lee*, 356 So.2d 276, 279

(Fla.1978). Appellants contend that hospitals and physicians are not similarly situated and we agree. While both may fall under a general classification, health care providers, they clearly are not similarly situated. Hospitals are corporate entities with larger budgets and much larger numbers of patients over which to spread costs. There are numerous differences between the two which justify the different treatment of these two groups by the statute. We find no merit to appellees' argument on this issue.

The hospitals have also objected to the statute as violating due process. To comply with the constitutional guarantee of due process of law, all legislative enactments must be rationally related to the achievement of a legitimate legislative purpose. *Rollins v. State,* 354 So.2d 61 (Fla. 1978). The provisions of the statute plainly satisfy the purpose of the statute, namely, to provide medical malpractice protection for Florida health care providers under terms accepted by the participants.

Finally, the issue has also been raised in this appeal of whether the Department failed to find that the assessments being levied were supported by competent, substantial evidence. The district court noted that the hearing officer, in an exhaustive recommended order which was later adopted by the Department, had concluded that the assessments levied by the Department were proper. In addition, the record reflects that the appellee hospitals were afforded the full protection of chapter 120. The correct standard of review of this type of administrative hearing is as follows:

> *[O]ur task is only to assure that the affected party was protected by adherence to Chapter 120 processes, that the dispositive finding is supported by substantial competent evidence appropriate to the issue, and*

> *that the agency was not "clearly erroneous or unauthorized," Gay v. Canada Dry Bottling Co. of Florida, Inc.*, 59 So.2d 788, 790 (Fla.1952), in interpreting the statute given in its charge to enforce.

Barker v. Board of Medical Examiners, 428 So.2d 720, 723 (Fla. 1st DCA 1983) (emphasis supplied). The district court correctly found that there was competent substantial evidence to support the need for an assessment and the hearing officer's recommendations. We find no merit in the appellees' challenge to this finding.

For these reasons, we upheld the constitutionality of section 768.54(3)(c) and reversed the decision of the district court.

It is so ordered.

ALDERMAN, C.J., and BOYD, OVERTON, McDONALD, EHRLICH and SHAW, J.J., concur.

ORDER DENYING REHEARING AND MANDATE

Dated November 4, 1983

SUPREME COURT OF FLORIDA

FRIDAY, NOVEMBER 4, 1983

CASE NO. 63,698

DEPARTMENT OF INSURANCE,
STATE OF FLORIDA, et al.,
Appellants,

v.

SOUTHEAST VOLUSIA HOSPITAL
DISTRICT, et al.,
Appellees.

CASE NOS. 63-699 & 63,751

District Court of Appeal, 1st District -
Nos. AN-412 & AN-367

CONSOLIDATED CASES

FLORIDA PATIENT'S COMPENSATION
FUND, et al.,
Appellants,

v.

SOUTHEAST VOLUSIA HOSPITAL
DISTRICT, et al.,
Appellees.

Upon consideration of the Motions for Rehearing filed in the above cause by attorneys for Appellees SOUTHEAST VOLUSIA HOSPITAL DISTRICT, et al., and HIGHLANDS COUNTY HOSPITAL DISTRICT, et al., and responses thereto,

IT IS ORDERED that said Motions be and the same are hereby denied.

A True Copy
TEST:

Sid J. White
Clerk, Supreme Court

By: /s/ Tanya Carroll
Deputy Clerk

MANDATE

Supreme Court of Florida

To the Honorable, the Judges of the District Court of Appeal, First District

WHEREAS, in that certain cause filed in this Court styled:

.....

DEPARTMENT OF INSURANCE, STATE OF FLORIDA, et al. v. SOUTHEAST VOLUSIA HOSPITAL DISTRICT, et al.;
FLORIDA PATIENT'S COMPENSATION FUND, et al. v. SOUTHEAST VOLUSIA HOSPITAL DISTRICT, et al.

Case No. 63698, 63699 & 63751

Your Case No. AN-412 & AN-367

The attached opinion was rendered on June 9, 1983 & September 15, 1983,

YOU ARE HEREBY COMMANDED that further proceedings be had in accordance with said opinion, the rule of this Court and the laws of the State of Florida.

WITNESS the Honorable James E. Alderman

Chief Justice of the Supreme Court of Florida and the Seal of said Court at Tallahassee, the Capital, on this 4th day of November 1983

/s/ Sid J. White
Clerk of the Supreme Court of Florida.

OPINION OF FIRST DISTRICT COURT OF APPEAL OF FLORIDA

SOUTHEAST VOLUSIA HOSPITAL DISTRICT, et al.,
Appellants,

v.

STATE of Florida, DEPARTMENT OF INSURANCE,
and Florida Patient's Compensation Fund,
Appellees.

HIGHLANDS COUNTY HOSPITAL DISTRICT, et al.,
Appellants,

v.

STATE of Florida, DEPARTMENT OF INSURANCE,
and Florida Patient's Compensation Fund,
Appellees.

Nos. AN-412, AN-367.

District Court of Appeal of Florida,
First District.

May 17, 1983.

Rehearing Denied May 27, 1983.

ERVIN, Judge.

In these consolidated appeals from a final order of the Department of Insurance (Department) levying $17,046,190.00 in assessments against participants in the Florida Patient's Compensation Fund (Fund), appellants contend, inter alia, that Section 768.54(3)(c), Florida Stat-

utes (1981),[1] is unconstitutional in that it amounts to an unlawful delegation of legislative power. We agree and

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1. Section 768.54(3)(c), Florida Statutes (1981), provides, in pertinent part:

> (c) *Fees and assessments*—Annually, each health care provider, as set forth in subsection (2), electing to comply with paragraph (2)(b) shall pay the fees established under this act, for deposit into the fund, which shall be remitted for deposit in a manner prescribed by the Insurance Commissioner. . . . For the first year of membership, each participating health care provider shall pay a *base fee* for deposit into the fund in the amount of $1,000 for any individual, or $300 per bed for any hospital. . . . The *base fee* charged after the first year of participation shall be $500 for any individual, or $300 per bed for any hospital. The *base fees* to be paid by those health care providers defined in subparagraphs (1)(b)5., 6., 7., and 8. shall be established by the fund on an actuarially sound basis. In addition, after the first year of operation, *additional fees* may be charged but shall be appropriately prorated for the portion of the year for which the health care provider participated in the fund, based on the following considerations:
>
> 1. Past and prospective loss and expense experience in different types of practice and in different geographical areas within the state;
>
> 2. The prior claims experience of the members covered under the fund; and
>
> 3. Risk factors for persons who are retired, semi-retired, or part-time professionals.
>
> Such *base fees* may be adjusted downward for any fiscal year in which a lesser amount would be adequate and in which the *additional fee* would not be necessary to maintain the solvency of the fund. Such *additional fee* shall be based on not more than two geographical areas with three categories of practice and with categories which contemplate separate risk ratings for hospitals, for health maintenance organizations, for ambulatory surgical facilities, and for other medical facilities. . . . Participants shall only be liable for *assessments* for claims from years during which they were members of the fund; in cases in which a participant is a member of the fund for less than the total fiscal year, a member shall be subject to *assessments* for that year on a pro rata basis determined by the percentage of participation for the year. . . . *Additional fees, assessments,* or *refunds* shall be set by the Insurance Commissioner after consultation with the board of governors of the fund. . . . If the

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reverse on that point without passing on the other issues raised.[2]

Footnote continued—

> fund determines that the amount of money in an account for a given fiscal year is in excess of or not sufficient to satisfy the claims made against the account, the fund shall certify the amount of the projected excess or insufficiency to the Insurance Commissioner and request the Insurer Commissioner to levy an *assessment* against or *refund* to all participants in the fund for that fiscal year prorated based on the number of days of participation during the year in question. The Insurance Commissioner shall order such *refund* to, or levy such *assessment* against, such participants in amounts that fairly reflect the classifications prescribed above and are sufficient to obtain the money necessary to meet all claims for said fiscal year. *In no case shall any assessment for a particular year against any health care provider, other than those health care providers defined in subparagraphs (1)(b)1., 5., 6., and 7., exceed an amount equal to the fees originally paid by such health care provider for participation in the fund for the year giving rise to such assessment.*

(emphasis supplied) Although this section has undergone extensive changes since its enactment in 1975, *see* Chapters 76-168, 76-260, 77-64, 77-174, 77-457, 78-47, 79-178, 80-91, 80-328, 81-318, 82-236, 82-243, 82-386, 82-391, Laws of Florida, our concern in this case is directed toward the 1981 version, set out above, because the assessments in question were certified and levied in late 1981 and early 1982.

2. Appellant, Highlands County Hospital District, contends that the Department incorrectly interpreted section 768.54(3)(c) and then failed to present competent, substantial evidence before the hearing officer to support its position. We find no merit in that argument, particularly in view of the fact that appellants were afforded a full administrative hearing on the issues raised, and the hearing officer, in an exhaustive recommended order, which the Department adopted, concluded that the assessments levied by the Department were proper. In such circumstances our review is limited to the following standard:

> When in Section 120.57 proceedings to construe and apply a nonpenal regulatory statute an independent hearing officer and the agency agree on a dispositive finding, there is little cause for a district court of appeal to debate whether the matter in issue is more nearly adjudicative fact or statutory policy and whether the hearing officer's or the agency's finding must prevail. See *McDonald v. Dept. of Banking and Finance*, 346 So.2d 569, 579 (Fla. 1st DCA 1977). *In such*

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In response to what has been described as a medical malpractice insurance crisis, the Florida legislature enacted the "Medical Malpractice Reform Act of 1975"[3] which, in

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Footnote continued—

> *a case our task is only to assure that the affected party was protected by adherence to Chapter 120 processes, that the dispositive finding is supported by substantial competent evidence appropriate to the issue, and that the agency was not "clearly erroneous or unauthorized," Gay v. Canada Dry Bottling Co. of Florida, Inc.*, 59 So.2d 788, 790 (Fla. 1952), in interpreting the statute given in its charge to enforce.

Barker v. Board of Medical Examiners, 428 So.2d 720 (Fla. 1st DCA 1983) (emphasis supplied). The record reflects that appellants were afforded the full protections of Chapter 120, that there was competent substantial evidence to support the hearing officer's recommendations and that the Department's actions were not clearly erroneous or unauthorized and we therefore reject this point.

All appellants also challenge the constitutionality of section 768.54(3)(c), both facially and as applied to them, on grounds of unlawful delegation, equal protection, due process and the pledging of public credit for private purposes. Although the hearing officer, correctly, did not pass on these constitutional issues, they are properly before this court for consideration. *See Key Haven Associated Enterprises, Inc. v. Board of Trustees of the Internal Improvement Trust Fund*, 427 So.2d 153 (Fla.1982). Because we find the issue of unlawful delegation to be dispositive, we do not address the remaining constitutional issues raised. *See Askew v. Cross Key Waterways*, 372 So.2d 913, 918 (Fla. 1978).

3. The Medical Malpractice Reform Act has been a source of controversy since its inception. It has, for example, been suggested that the malpractice "crisis" in 1975 never existed and was merely a creation of the insurance industry. *See* Cunningham & Lane, *Malpractice—The Illusory Crisis*, 54 Fla.Bar J. 114 (1980); *Pinillos v. Cedars of Lebanon Hospital Corp.*, 403 So.2d 365, 369 (Fla.1981) (Sundberg, C.J., Dissenting). The Act has been subject to a number of constitutional challenges with varying results. *See Pinillos* (exception to collateral source rule in malpractice actions does not violate equal protection rights); *accord Lower Florida Keys Hospital District v. Skelton*, 404 So.2d 832 (Fla. 3d DCA 1981). *See also Carter v. Sparkman*, 335 So.2d 802 (Fla. 1976) (medical mediation panels are not an unconstitutional denial of access to courts); *Aldana v. Holub*, 381 So.2d 231 (Fla. 1980) (medical mediation panels held unconstitutional on due

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part, created the "Florida Patient's Compensation Fund", the purpose of which was to limit participants' liability in malpractice actions to $100,000.00 per claim and $500,000.00 per occurrence, while providing that the balance of awards would be paid by the Fund. *See* Chapter 75-9, Laws of Florida. The Act permits all health care providers, other than hospitals, *i.e.*, physicians, osteopaths, podiatrists, health maintenance organizations (HMO), ambulatory surgical centers and other medical facilities, to participate in the fund if they so choose, but hospitals are required to join unless they can demonstrate financial responsibility for malpractice claims, in which case they may be exempt from participation. Such exemption carries with it the consequence that the hospital be barred from the limited liability provided by the Fund.

The Fund is to be financed by three sources of monies: (1) *base fees* of $1,000.00 per individual and $300.00 per hospital bed during the first year of participation and, for later years, $500.00 per individual and $300.00 per hospital bed; (2) *additional fees*; and (3) *assessments*. When it became evident, in 1976, that the threat of a medical malpractice crisis still loomed, the legislature amended section

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Footnote continued—

process grounds); *Mercy Hospital, Inc. v. Menendez*, 371 So.2d 1077 (Fla. 3d DCA 1979), *after remand*, 400 So.2d 48 (Fla. 3d DCA 1981) (requirement that Fund be joined as party to malpractice action upheld); *McCarthy v. Mensch*, 412 So.2d 343 (Fla. 1982) (admissibility of conclusion of medical mediation panel not violative of due process rights); *The Florida Bar, In re: Rules of Civil Procedure*, 429 So.2d 311 (Fla.1983) (Fla.R.Civ.P. 1.450(e), prohibiting reference to insurance coverage in medical malpractice actions, upheld). *See also* Spence, J.B. & Roth, J., *Closing the Courthouse Door; Florida's Spurious Claims Statute*. 11 Stetson L.Rev. 283 (1982) (suggesting that the claims statute, requiring the loser in malpractice actions to pay the prevailing party's attorney's fee, violates constitutional rights of equal protection and access to courts).

768.54(3)(c) to offer greater protection for physicians[4] by providing that assessments for Fund participants, other than hospitals, could not exceed "an amount equal to the fees or assessments originally paid by such health care provider for participation in the fund, for the year giving

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4. The preamble to Chapter 76-260, Laws of Florida, expresses the legislature's intent in amending section 768.54(3)(c), as follows:

> WHEREAS, despite the responsive and responsible actions of the 1975 session of the Legislature, professional liability insurance premiums for Florida *physicians* have continued to rise and, according to the best available projections, will continue to rise at a dramatic rate, and
>
> WHEREAS, insurance companies across America are continuing to withdraw from the medical professional liability insurance market so that such insurance, even at exorbitant rates, is becoming virtually unavailable in the voluntary private sector, and
>
> WHEREAS, the maximum rates for essential medical specialists such as cardio-vascular surgeons, neurosurgeons, orthopedic surgeons, and anesthesiologists range from $8,200 in *physician*-owned trusts to $24,000 through the JUA, and
>
> WHEREAS, a certain amount of these premium costs are passed on to the consuming public through higher costs for health care services in addition to the heavy and costly burden of "defensive medicine" as *physicians* are forced to practice with an overabundance of caution to avoid potential litigation, and
>
> WHEREAS, this insurance crisis threatens the quality of health care services in Florida as *physicians* become increasingly wary of high-risk procedures and are forced to downgrade their specialties to obtain relief from oppressive insurance rates, and
>
> WHEREAS, this crisis also poses a dire threat to the continuing availability of health care in our state as new *young physicians* decide to practice elsewhere because they cannot afford high insurance premiums and as *older physicians* choose premature retirement in lieu of a continuing diminution of their assets by spiraling insurance rates, and
>
> WHEREAS, our present tort law/liability insurance system for medical malpractice will eventually break down and costs will continue to rise above acceptable levels, fundamental reforms of said tort law/liability insurance system must be undertaken, and
>
> WHEREAS, the continuing crisis proportions of this compelling social problem demand immediate and dramatic legislative action. . . .
>
> **(emphasis supplied)**

rise to such deficit assessment." Chapter 76-260, § 6, Laws of Florida.[5]

Although the Fund commenced operation in 1975, it was not until 1978, when deficits were first anticipated, that additional fees ranging from $1,749.00 to $12,619.00 were recommended by the Fund.[6] A public hearing was held by the Department to consider the issue of additional

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5. Although the 1976 amendment to section 768.54(3)(c) limited assessments for physicians to the amount of "fees *or* assessments" originally paid, that language was again amended, in 1978, to limit such liability to only the amount of "fees" originally paid. *See* Ch. 78-47; § 2, Laws of Florida. The 1981 version of that section, with which we are concerned, likewise refers only to "fees" originally paid.

6. The Fund obtained the services of an independent actuarial firm to determine the amount of monies needed to satisfy claims anticipated for the fund year 1978-79 and, based on the actuarial report, requested the following additional fees for that year.

CLASS I PHYSICIANS	
Dade/Broward Co.	$2,233.00
Rest of State	1,749.00
CLASS II PHYSICIANS	
Dade/Broward Co.	4,420.00
Rest of State	3,549.00
CLASS III PHYSICIANS	
Dade/Broward Co.	12,619.00
Rest of State	10,297.00
HOSPITALS (per occupied bed)	222.00
AMBULATORY SURGICAL CENTERS (per 100 patients)	22.00
HEALTH MAINTENANCE ORGANIZATIONS (per 100 subscribers)	150.00
PROFESSIONAL ASSOCIATIONS	20% of additional fee to be paid by each individual member

Had that recommendation been approved, the Fund contends, fees totaling $18,879,530.00 would have been generated for 1978-79, which would have prevented the present deficit and would have fairly allocated the costs to all participants.

fees, but, after all those present, with the sole exception of the Fund, spoke out against additional fees, the Department concluded that no change in the existing fee schedule was appropriate at that time.[7] Finally, in October 1981, the Fund certified to the Department deficiences for the fund years 1977-78 and 1978-79 totaling some $17,000,000.00[8] and the Department levied assessments against Fund participants to make up the deficiency. The dispute, which is the subject of this appeal, arose not over the total deficiency certified by the Fund, but over the Department's allocation of the deficiency among the Fund participants. The Department, using an indicated rate method, first determined the assessments due from each of the eight categories of health care providers as defined by section 768.54(1)(b) 1.-8., then interpreted section 768.54(3)(c) as precluding assessments against physicians, osteopaths, podiatrists and professional associations which would exceed the amount of fees paid by those individuals for participation in the Fund for the year found to be deficient. The Department further construed the statute as providing for unlimited assessment liability for all other health care providers. As a result, $10,500,000.00 in additional assessments for claims stemming from charges of physician malpractice was assessed against the hospitals, HMO's ambulatory surgical centers and other medical facilities participating in the Fund, rather than against the physicians.

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7. Although appellants contend that there was insufficient public notice of the hearing on the issue of additional fees in 1978, and that their interests, therefore, were not adequately represented before the Department at the hearing, we find that the record clearly refutes that argument.

8. On October 31, 1981, the Fund certified to the Department a deficiency of $1,350,672.00 for the Fund year 1977-78 and, on January 18, 1982 it certified an additional deficiency for the same year totaling $1,759,591.00. On January 18, 1982 the Fund also certified a deficiency of $13,935,927.00 for the Fund year 1978-79.

Appellants contend, and we agree, that section 768.54 (3)(c) amounts to an unlawful delegation of legislative power due to insufficient standards and guidelines establishing the method of assessments. Before addressing the merits of this argument, we must, however, dispose of two preliminary issues raised by the Fund in contesting the appellants' right to challenge the constitutionality of this statute. The Fund first asserts that because appellants voluntarily elected to participate in the Fund, they are therefore estopped from now challenging the constitutionality of a statute from which they have benefited. We agree that the doctrine of equitable estoppel may be applied in appropriate cases to bar a constitutional challenge to a statute or ordinance. *See 759 Riverside Avenue, Inc. v. Marvin*, 109 Fla. 473, 147 So. 848 (1933) (corporation, accepting charter from state, must do so subject to conditions prescribed by law and may not later challenge constitutionality thereof); *McNulty v. Blackburn*, 42 So.2d 445 (Fla.1949) (petitioner who voluntarily accepted pension benefits for six years was estopped to challenge constitutionality of pension act); *State ex rel. Watson v. Gray*, 48 So.2d 84 (Fla.1950) (candidate who accepted benefits of election law estopped from challenging that law after losing election); *Baker v. State Road Department*, 79 So.2d 511 (Fla.1955) (citizens who failed to intervene in bond validation proceedings were estopped from later seeking to enjoin sale of bonds; *State ex rel. Bankers Life & Casualty Company v. Village of North Palm Beach*, 138 So.2d 378 (Fla. 2d DCA 1962) (landowner who accepted benefits from village for three years estopped from challenging act creating village). Nevertheless, while it is generally recognized that one who invokes the provisions of a law or partakes of advantages thereunder may not then be heard to challenge the constitutionality thereof, *see Bon Ton Cleaners & Dyers, Inc. v. Cleaning, Dyeing & Pressing*

Board, 128 Fla. 533, 176 So. 55 (1937); 10 Fla.Jur.2d *Constitutional Law* § 68 (1979), there are two recognized exceptions to this rule: First, "[t]he rule is well settled in this country that when one accepts the *general benefits* of an act he is not estopped to challenge the constitutionality of any separable portion thereof under which he has not given or accepted benefits." *Lollie v. General American Tank Storage Terminals*, 160 Fla. 208, 34 So.2d 306, 308 (1948) (e.s.) (employer not estopped from challenging constitutionality of section of worker's compensation act despite acceptance of general benefits of act). *See also Mojave River Irrigation District v. Superior Court*, 202 Cal. 717, 262 P. 724 (Cal. 1927); *City of Los Angeles v. Los Angeles City Water Company*, 177 U.S. 558, 20 S.Ct. 736, 44 L.Ed. 886 (1900); 10 Fla.Jur.2d *Constitutional Law* § 68 (1979). Second, the "acceptance of the benefits of an act *under compulsion* will not preclude an attack upon the statute." *Hialeah Race Course, Inc. v. Gulfstream Park Racing Ass'n., Inc.*, 245 So.2d 625, 629 (Fla.1971) (e.s.) (Gulfstream's acceptance of benefits of statute for twenty years did not estop it from challenging constitutionality of statute). *See also* 16 Am.Jur.2d *Constitutional Law* § 211 (1979); 10 Fla.Jur.2d *Constitutional Law* § 68 (1979). We find that both exceptions apply in this case to preclude application of the doctrine of estoppel. There can be little doubt that appellants have generally benefited from the operation of section 768.54. Section 768.54(3)(c) is, however, a separable portion of that statute dealing only with the mechanics of financing the Fund, and, as such, may be challenged despite appellants' utilization of the general provisions of the statute.

Although the Fund contends that appellants voluntarily elected to participate in the Fund, we also find that their participation was made virtually compulsory by section 768.54(2)(a), which, while authorizing voluntary par-

ticipation for all health care providers other than hospitals, made participation mandatory for all hospitals in Florida[9] unless they could qualify for exemption by demonstrating financial responsibility for claims through one of the following means:

> 1. Post bond in an amount equivalent to $10,000 per claim for each hospital bed in said hospital, not to exceed a $2,500,000 annual aggregate;
>
> 2. Prove financial responsibility in an amount equivalent to $10,000 per claim for each hospital bed in said hospital, not to exceed a $2,500,000 annual aggregate, to the satisfaction of the board of governors of the fund, through the establishment of an appropriate escrow account;
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> 3. Obtain professional liability coverage in an amount equivalent to $10,000 or more per claim for each bed in said hospital from a private insurer, from the Joint Underwriting Association established under subsection 627.351(7), or through a plan of self-insurance as provided in s. 627.357; however, no hospital shall be required to obtain such coverage in an amount exceeding $2,500,000 annual aggregate.

§ 768.54(2)(c), Fla.Stat. (1977). Given those alternatives, we conclude that appellants' participation in the Fund cannot realistically be said to be voluntary; therefore they are not estopped from challenging the constitutionality of section 768.54(3)(c).

We also reject the Fund's contention that appellants lack standing to raise constitutional issues. It is funda-

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9. Section 768.54(2)(a) was amended in 1980 to exempt from participation any hospital operated by an agency of the state regardless of such hospital's ability to show financial responsibility for claims. *See* Ch. 80 328, § 1, Laws of Florida.

mental that a person may not challenge the constitutionality of a statute "unless his rights are in some way injuriously and directly affected" by the operation of the statute. *E.M. Watkins & Co., Inc. v. Board of Regents,* 414 So.2d 583, 588 (Fla. 1st DCA 1982). *See also Rhaney v. Dobbs House, Inc.,* 415 So.2d 1277 (Fla. 1st DCA 1982); *Robbins v. Rophie Shoes, Inc.,* 413 So.2d 839 (Fla. 1st DCA 1982); *Jack Eckerd Corporation v. Coker,* 411 So.2d 1026 (Fla. 1st DCA 1982); *Miami Beach Kennel Club, Inc. v. Board of Business Regulation,* 265 So.2d 373 (Fla. 3d DCA 1972). It is without question that appellants are directly financially affected by the operation of section 768.54(3)(c) in that they face a potential increased liability of $10,500,000.00 for malpractice claims incurred by physicians.

Although we find that appellants have the requisite standing to challenge section 768.54(3)(c), it is equally clear that they "may not challenge those portions of an enactment which do not adversely affect [their] personal or property rights." *Sandstrom v. Leader,* 370 So.2d 3, 4 (Fla.1979). *See also Greenway v. State,* 413 So.2d 23 (Fla.1982). Therefore, appellants have standing to challenge only section 768.54(3)(c), and not all of section 768.54, because they are adversely affected only by that portion of the statute.

We turn then to what we consider to be the dispositive issue: whether section 768.54(3)(c) amounts to an unconstitutional delegation of legislative powers. That the legislature may delegate non-legislative duties to administrative agencies is no longer subject to dispute. In Florida, however, such delegation is subject to the constitutional mandate that "[t]he powers of the state government shall be divided into legislative, executive and judicial branches. No person belonging to one branch shall exer-

cise any powers appertaining to either of the other branches unless expressly provided herein." Art. II, § 3, Fla. Const. Although rejected by courts in some jurisdictions and the subject of criticism in others,[10] the doctrine of nondelegation remains alive and well in Florida jurisprudence. *See Askew v. Cross Key Waterways*, 372 So.2d 913, 924 (Fla. 1978); *Hialeah, Inc. v. Gulfstream Park Racing Association, Inc.*, 428 So.2d 312 (Fla. 4th DCA 1983). The doctrine is premised on the rule that "[t]he Legislature may not delegate the power to enact a law, or to declare what the law shall be, or to exercise an unrestricted discretion in applying a law . . . ." *State, Department of Citrus v. Griffin*, 239 So.2d 577, 580 (Fla.1970). "The distinction is said to be one between 'delegation of the power to make the

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10. In *Cross Key Waterways*, the Florida Supreme Court, reiterating this state's adherence to the nondelegation doctrine, noted that

> Professor [Kenneth Culp] Davis [of the University of Chicago College of Law] maintains that there should be a shift in emphasis from legislatively imposed standards for administrative action to procedural safeguards in the administrative process. He supports his rationale by citation to federal decisions as well as decisions from a minority of state court jurisdictions. His premises are that (1) strict adherence to the nondelegation doctrine would stultify the administrative process; (2) the doctrine, in fact, has been used as a label to invalidate legislation of which courts disapprove without any rational distinction between standards approved and those disapproved; and (3) the danger of arbitrary or capricious administrative action is best met through procedural due process safeguards in the administrative process.
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> * * *
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> Although the Davis view is an entirely reasonable one as demonstrated by its adoption in the federal courts and a minority of state jurisdictions, nonetheless, it clearly has not been the view in Florida. . . . Should this Court, then, accept the invitation of appellants to abandon the doctrine of nondelegation of legislative power which is not only firmly embedded in our law, but which has been so continuously and recently applied? . . . We believe *stare decisis* and reason dictate that we not.

372 So.2d at 922-924 (citations omitted).

law, which necessarily involves a discretion as to what the law shall be, and the conferring of authority or discretion in executing the law pursuant to and within the confines of the law itself.'" *Brewer v. Insurance Commissioner and Treasurer*, 392 So.2d 593, 595 (Fla. 1st DCA 1981) (citing *Connor v. Joe Hatton, Inc.*, 216 So.2d 209, 211 (Fla.1966)). No unconstitutional delegation of legislative power occurs, however, if a statute, conferring duties and powers on an administrative agency, contains sufficient standards and guidelines under which the agency is to act:

> [S]tatutes granting power to administrative agencies must clearly announce adequate standards to guide the agencies in the execution of the powers delegated. The statute must so clearly define the power delegated that the administrative agency is precluded from acting through whim, showing favoritism, or exercising unbridled discretion.

Lewis v. Bank of Pasco County, 346 So.2d 53, 55-56 (Fla. 1977). "When legislation is so lacking in guidelines that neither the agency nor the courts can determine whether the agency is carrying out the intent of the legislature in its conduct, then, in fact, the agency becomes the lawgiver rather than the administrator of the law." *Cross Key Waterways*, 372 So.2d at 918-919. *See also Solimena v. State, Department of Business Regulation*, 402 So.2d 1240, 1245 (Fla. 3d DCA 1981).

The determination of whether section 768.54(3)(c) amounts to an unlawful delegation turns, therefore, on whether the legislature, in enacting that section, provided sufficient standards and guidelines to the Department for its proper administration of the Fund. At the outset we reject the Fund's assertion that the legislature was overly explicit in enacting this section. Even a cursory examination evidences to us an almost total absence of guidelines

and standards for the establishment of fees and assessments. As far as base fees for individuals and hospitals are concerned, the statute is explicit in setting such fees for the first year of participation and for ensuing years. For all other health care providers electing to participate in the Fund, however, base fees are to be "established by the *fund* on an actuarially sound basis." § 768.54(3)(c) (e.s.). As to the latter class, the statute leaves to the Fund the sole discretion for establishing the amount of such fees, rather than the agency that is delegated the responsibility for administering the statutes.

Section 768.54(3)(c) also provides that base fees in general may be "adjusted downward" for any fiscal year in which a "lesser amount would be adequate," but again no statutory guidelines are provided to assist in making such a determination, which is apparently also left to the sole discretion of the Fund, not the Department.

Additional fees "may" be charged[11] on a prorated basis, upon consideration of the following factors:

1. Past and prospective loss and expense experience in different types of practice and in different geographical areas within the state;

2. The prior claims experience of the members covered under the fund; and

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11. As initially enacted, section 768.54(3)(c) provided that ". . . after the first year of operation additional fees *shall* be assessed . . ." Ch. 75 9, § 15, Laws of Fla. That section was not amended to read ". . . after the first year of operation, additional fees *may* be charged . . ." until 1978. Ch. 78-47, § 2, Laws of Fla. No explanation was given by any of the parties to this appeal for the Department's disregard of the statutory directive to charge additional fees between the years 1975 and 1978. The fact that additional fees were mandated by section 768.54(3)(c) during those years supports appellants' position that the establishment of such fees is a condition precedent to the levying of assessments.

3. Risk factors for person who are retired, semi-retired, or part-time professionals.

The statute does state that additional fees are to be based on "not more than two geographical areas with three categories of practice and with categories which contemplate separate risk ratings for hospitals, for health maintenance organizations, for ambulatory surgical facilities, and for other medical facilities," and are to be set by the Department after consultation with the Fund. It is otherwise silent, however, as to how or when additional fees are to be set and, most importantly, whether they are, as appellants insist, a prerequisite to the levying of assessments.

The most obvious absence of standards and guidelines is found in those parts of section 768.54(3)(c) dealing with assessments. The Fund is given total discretion in determining whether the monies collected in a given fund year are in excess of or insufficient to satisfy claims made against the fund year. In either case, the Fund is to "certify" the amount of excess or insufficiency to the Insurance Commissioner, who is then authorized to order a refund or levy an assessment as requested by the Fund. No guidance is given the Fund to assist it in determining whether a refund or an assessment is necessary, nor is there any provision for review by the Department of the certification to determine its accuracy. In fact, the record before us reveals that the Department merely accepted the amount certified by the Fund and levied assessments without making any attempt to verify the accuracy of the Fund's request.

The sole statutory standard for the levying of assessments appears to be the directive that the amounts must "fairly reflect the classifications prescribed above" and be sufficient to meet all claims for the fund year in question. This ambiguous standard has been interpreted by

the Fund as requiring application of the three factors set out above for the proration of additional fees to the eight categories of health care providers as defined in section 768.54(1)(b)1.-8. Appellants, on the other hand, interpret the phrase "classifications prescribed above" as referring only to the three factors relating to additional fees. The statute, unfortunately, offers no assistance in deciphering the legislative intent in creating the standard.

Finally, section 768.54(3)(c) limits assessments for physicians, osteopaths, podiatrists and professional associations to "an amount equal to the fees originally paid by such health care provider for participation in the fund for the year giving rise to such assessment." The hearing officer below concluded that since the language "imposed a 'cumulative' cap on the liability for physicians, osteopaths and podiatrists for assessments for deficits for a given coverage year, . . . those participants are liable only for a maximum of either $1,000.00 or $500.00 in assessments, depending upon whether the year in question was their first year or a subsequent year of participation." While that interpretation is shared by the Fund and the Department, appellants offfer two alternative interpretations which are equally plausible.[12] We find, however, that

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12. Appellants first insist that the proper interpretation of section 768.54(3)(c) requires an actuarially sound Fund made up of base fees *and* additional fees, fairly reflecting the statutory classifications. Assessments, they contend, are only a means of fine tuning the Fund if deficiencies occur. If, however, the second step, that of establishing additional fees, is skipped, as the Department has done each year since the inception of the Fund, appellants next contend that there is no statutory prohibition barring multiple assessments against all Fund participants. For example, if the Fund year 1977-78 were found to be deficient, physicians could each year be assessed an amount equal to the fees they originally paid for participation during that Fund year until such deficiency was eliminated. When asked at deposition whether the latter interpretation had any validity, the Department's General Counsel, while observing that section 768.54(3)(c) was susceptible to many interpretations, answered in the affirmative.

it is impossible to determine, from the statutory language employed, the legislature's actual intent and that, as in the other portions of this poorly drafted statute, the absence of standards and guidelines for the allocation of assessments among Fund participants renders section 768.54(3)(c) constitutionally infirm.

It is our opinion that section 768.54(3)(c) is so lacking in standards and guidelines that neither the Fund, the Department, nor this court can determine whether the legislature's intent in enacting this statute is being properly administered by the Department. We therefore conclude that section 768.54(3)(c) is unconstitutional as an unlawful delegation of legislative authority.

Accordingly, this cause is REVERSED and remanded for further proceedings not inconsistent with this opinion.

MILLS, J., and PEARSON, TILLMAN (Ret.), Associate Judge, concur.

(Filed July 28, 1982)

OFFICE OF TREASURER
INSURANCE COMMISSIONER
STATE OF FLORIDA
TALLAHASSEE 32301

Case Nos. 82-FPCF-01B
82-FPCF-02B
82-FPCF-03B

DOAH Case Nos. 82-530
82-776
82-571

Bill Gunter
State Treasurer
Insurance Commissioner
Fire Marshal

IN THE MATTER OF

FLORIDA PATIENT'S COMPENSATION FUND
Assessment for Fund Fiscal Years
1977-1978 and 1978-1979

FINAL ORDER

This cause having come on before the Insurance Commissioner for consideration, and the Insurance Commissioner having considered the Recommended Order of the Hearing Officer, dated June 22, 1982, the transcript of the hearing held March 30 - April 1, 1982, and being otherwise fully advised in the premises, it is hereby ORDERED that:

1. The Recommended Order of the Hearing Officer dated June 22, 1982 is hereby adopted and fully incorporated by reference.

2. The following amounts are hereby levied as assessments against the respective classes of health care providers who were members of the Florida Patient's Compensation Fund for the fiscal year 1977-1978:

Class 1	$ 386,138
Class 2	438,297
Class 3	831,048
Hospitals	1,374,827
All others	79,953

3. The following amounts are hereby levied as assessments against the respective classes of health care providers who were members of the Florida Patient's Compensation Fund for the fiscal year 1978-1979:

Class 1	$ 777,375
Class 2	503,398
Class 3	828,032
Professional Associations	302,400
Hospitals	11,480,624
Ambulatory Surgical Centers	33,259
Health Maintenance Organizations	10,839

4. Each health care provider shall pay an equal portion of the total amount of the assessment, as described in the above paragraphs, levied against the class of health care providers of which it, he or she is a member.

5. The Motion to Remand Proceedings to Division of Administrative Hearings, filed by the Petitioners, Southeast Volusia Hospital District, et al., and all other similar requests found in any of the exceptions or any other filings are hereby denied. The Petitioners maintain that the Hearing Officer did not rule specifically on any of their proposed findings, but only made a general statement

rejecting their findings. To the contrary, however, the Hearing Officer made over fifty express findings of fact. It is my conclusion that the Hearing Officer has thereby ruled specifically and expressly on all material and relevant proposed findings of fact.

In addition to these specific findings the Hearing Officer stated:

> Counsel for all parties submitted a proposed findings of fact for consideration by the Hearing Officer in entering this Recommended Order. To the extent that those proposed findings of fact are not contained in this Recommended Order, they have been specifically rejected as being either irrelevant to the issues involved in this proceeding, or as not having been supported by evidence of record. (Page 3 of Hearing Officer's Recommended Order)

Petitioners maintain in their motion and in their exceptions that this cause should be remanded to the Hearing Officer with instructions to identify which findings of fact were rejected as being irrelevant and which were rejected as being not supported by the record. As stated above it is my finding that the Hearing Officer's findings of fact resolved all the proposed findings of fact which were relevant or material to these proceedings. His *general* resolution of those findings of fact which are subordinate, cumulative, immaterial or unnecessary is clearly proper. In *Forrester v. Career Service Commission*, 361 So.2d 220 (Fla. 1st DCA 1978) the First District Court of Appeal stated:

> Pursuant to F.S. 120.57, a party has the right to raise pertinent factual issues for administrative determination, to submit proposed findings on those issues and to receive a ruling on each pertinent proposed

> finding . . . However, in so holding we stress that an agency head is not required to make explicit rulings on subordinate, cumulative, immaterial or unnecessary proposed facts. Those proposed findings which fall in such a category may be rejected by a simple statement that they are immaterial or irrelevant.

The rationale of *Forrester* is equally applicable to the rejection of findings of fact which have no support in the record. There is no error then in the Hearing Officer's failure to distinguish which facts were not supported by the record and which were simply immaterial and irrelevant.

Even if the Hearing Officer's failure to distinguish between findings rejected as not supported by evidence in the record and those rejected as being irrelevant or immaterial were to be considered material error, that error would be corrected by this Order. Since it is my finding that the Hearing Officer has specifically ruled on all findings which were relevant and material to the issues in the instant case, it must necessarily follow that any findings not specifically resolved were either unnecessary, immaterial, irrelevant, cumulative or subordinate. All such findings could have been rejected under the *Forrester* rationale, and hereby are rejected, with the simple statement that they were, and are, immaterial or irrelevant. Since §120.59(2) applies to *final orders* and not recommended orders, there would be no need for any remand.

6. The following findings are made relative to the exception submitted by the Pennington, Wilkinson and Dunlap law firm on behalf of the Petitioners in Case No. 82-530, Southeast Volusia Hospital District, et al. These exceptions generally do not point out why the Petitioners

consider the Hearing Officer's findings to be in err, nor do they request the Insurance Commissioner to make any specific findings. Nevertheless, the following responses are made:

(a) Exception number (1) is rejected for the reasons set forth in paragraph (5) above.

(b) Exceptions numbers (2) and (3) are rejected because it is my finding that the Fund is not an agency as that term is defined in §120.57(1) and is therefore not subject to Chapter 120. In addition, §768.54(1)(a) was amended in the 1982 session of the legislature and now states that the "Fund" is not a state agency, board or commission.

(c) Exception number (4) is rejected. While the Petitioners fail to identify in what manner they contend the Department has failed to meet its burden of proof, the Hearing Officer did find that the Department demonstrated that the method it proposed was the most feasible of all suggested alternatives under the existing law and recommended assessments consistent with the Department's proposed action. These findings are supported by competent substantial evidence and cannot be disturbed.

(d) Exception number (5) contests a specific finding of the Hearing Officer. This finding, however, is supported by competent substantial evidence and therefore should not be disturbed. The rationale of the Hearing Officer in making this finding was correct and is incorporated herein.

(e) Exception number (6) is rejected as not being relevant or supported by competent substantial evidence.

(f) Exception number (7) is rejected because not all facts stipulated to are relevant to the levying of the assessments.

(g) Exception number (8) is rejected for the same reasons set forth in paragraph (b) above.

(h) Exception number (9) is rejected because paragraph 1, page 3 of the Recommended Order is supported by competent substantial evidence.

(i) Exception number (10) is rejected as not being relevant or material. Even if this fact were true and supported by competent substantial evidence in the record, it would have no bearing on how the assessments should be levied.

(j) Exception number (11) is acknowledged. However, the recommended changes are not material to this final order and were not material to the decisions reached in the recommended order.

(k) Exception number (12) is rejected. There was no need for the Hearing Officer to set out the dollar amounts of the assessments. These amounts were identified in the proposed orders of the Department which orders the Hearing Officer identified in the Recommended Order. In any event these amounts are set out in paragraphs (2) and (3) above.

(l) Exception number (13) is rejected for the same reason as number (12). In addition, there was no error in the Hearing Officer's failure to make specific findings of fact re the losses caused by the physicians and hospitals for the fund years 1977-1978 and 1978-1979. The Hearing Officer found that the indicated rates method reflected the statutory classifications prescribed by the statute and, at the same time, provided the immediate funds necessary to meet all claims against the Fund. In addition, he found that the method used by the Department included consideration of the expected losses by class. This is all that

was necessary to support the conclusion that the proposed assessments were correct.

In any event, the requested numbers are not material or relevant because the physician members were assessed the maximum amount allowable under §768.54, Fla. Stat. No one at the proceeding contended that the physician's share of the assessments should have been less. It did not matter then what the exact amount of their losses were.

(m) Exception number (14) is acknowledged. It is my finding after reviewing the Recommended Order that the Hearing Officer probably intended that the referenced date read 1978-1979. Certainly no harm or material error resulted from this mistake. The information in the column is accurate with respect to the 1977-1978 year except that no additional fees were recommended by any actuary or by the Fund.

(n) Exception number (15) is rejected because it is not material or relevant to the levying of the assessment. The second paragraph in paragraph (1) above is applicable here.

(o) Exception number (16) is not relevant or material because all of the Petitioners were allowed to participate in the §120.57(1) proceeding.

(p) Exceptions numbers (17) through (19) are rejected as not being relevant or material to the levying of the assessments.

(q) Exceptions numbers (20) and (21) require no response.

(r) Exception number (22) is contrary to the findings of the Hearing Officer and is rejected for the reasons set forth in the Recommended Order.

(s) Exception number (23) is acknowledged.

(t) Exception number (24) is specifically rejected as not being relevant. All Petitioners were given full opportunity to contest the proposed order in a §120.57(1) proceeding. There was also evidence presented that notice was given to some of the Petitioners prior to issuance of the proposed order.

(u) Exception number (25) is rejected because exhibit number P-51 was not relevant or material. The exhibit contained projections of possible future assessments. These projections, even if proven to be correct, would not alter the way the current assessments are to be levied.

(v) Exceptions numbers (26) and (27) are not material or relevant to the levying of the assessments. These exceptions, if relevant to anything, would be relevant to the setting of the fees in 1977-1978 and 1978-1979.

(w) Exception number (28) is not supported by competent substantial evidence. The retrospective rating plan did make a general reference to the method to be used in levying the assessments. In any event this exception is not relevant or material because it is my express finding that the method for levying the assessment is based directly on the language of the statute and is not based on the retrospective rating plan.

(x) Exception number (29) is contrary to the findings of the Hearing Officer and is rejected for the reasons set forth in the Recommended Order. See also the response to exception number (4).

(y) Exception number (30) does not appear to present any relevant or material issues.

(z) Exceptions numbers (31) and (32) are rejected as not being supported by competent substantial evidence and as not being relevant or material.

(aa) Exception number (33) is contrary to the findings of the Hearing Officer and is rejected for the reasons set forth in the Recommended Order.

(bb) Exception number (34) is rejected as not being relevant or material and as not being supported by competent substantial evidence.

(cc) Exception number (35) is rejected because the Department concurs in the Hearing Officer's findings for the reasons set out in the Recommended Order.

(dd) Exceptions numbers (36) through (38) are rejected as being contrary to the findings in the Recommended Order of the Hearing Officer. They are rejected on the basis of the rationale set forth in the Recommended Order.

(ee) Exception number (39) is rejected because there is no basis for the undersigned to require the Hearing Officer to set forth the portions of the record on which each finding is based. In any event, the Hearing Officer's findings are clear and concise as is and do not require citations to the transcript of the proceedings.

7. Exceptions and proposed findings were also submitted on behalf of the Petitioners, Southeast Volusia Hospital District, et al., by the law firm of Carlton, Fields, Ward, Emmanuel, Smith and Cutler. This document entitled "Exceptions to Recommended Order and Motion to Remand" requests the Insurance Commissioner to reject certain findings of facts and conclusions of law of the Hearing Officer and to adopt the exceptions contained therein. The following response and findings are made to this request:

(a) Exception number (1) is rejected. The figures cited by the Hearing Officer are consistent with the cor-

rections made to the pre-trial stipulation on the record at the beginning of the hearing held in this matter. (See page 34 of the trial transcript).

(b) Exception number (2) is rejected because the Hearing Officer's Finding of Fact is supported by competent substantial evidence.

(c) Exception number (3) is rejected for the reasons set forth an paragraph 6(b) above.

(d) Exception number (4) sets forth 47 proposed findings of fact which the Petitioners maintain should have been included in the Hearing Officer's Recommended Order. The following response is made to each proposal:

(1) The Hearing Officer specifically found that the notices of assessments dated February 1, 1982, February 17, 1982 and January 22, 1982 "fairly reflected" the required statutory classifications; that the amounts requested were necessary to meet the claims against the Fund for the years in question; and that the procedure used by the Department in spreading liability for the assessments was appropriate in light of the statute. These findings are supported by competent substantial evidence in the record. These findings are also sufficient to demonstrate the correctness of the Department's proposed action. Proposed finding of fact number (1) must therefore be rejected.

(2) Findings of Fact numbers (2) and (3) are rejected. The assessments for the respective years are related to the expected losses caused by each class of health care provider to the extent permitted given the statutory limitations. Findings of Fact relative to losses and assessments which exceed the statutory limitation are not necessary, relevant or material.

(3) Finding of Fact number (4) is rejected because the cited numbers are not relevant or material to the cur-

rent assessment. Those figures are based on speculative projections and may or may not prove to be the basis for *future* assessments.

(4) Finding of Fact number (5) is not supported by competent substantial evidence. Evidence was presented at the hearing that notice of the rate hearing for the 1978-1979 year was published in the Florida Administrative Weekly. There was also testimony that notice was sent to persons on a mail out list. Some of the Petitioners even had representatives present at the hearing.

(5) Finding of Fact number (6) is rejected because it is neither relevant nor material to levying the current assessment.

(6) Finding of Fact number (7) is not supported by competent substantial evidence. The Hearing Officer did find that on occasion (but not consistently) the Fund had exceeded the $100,000 per person year limit on payouts of claims. However, as pointed out by the Hearing Officer this finding is not, in any event, relevant to the levy of the assessments in the instant case.

(7) Findings of Fact numbers (8)-(18) and (21)-(22) concern the setting and collection of fees for membership in the Fund for the 1977-1978 and 1978-1979 fund years. The facts presented therein have no bearing on the decision of how to levy the assessments in the instant case. These findings are rejected therefore as being irrelevant and immaterial.

(8) Findings of Fact numbers (19), (20), (23) and (24) deal with the amount of losses incurred by hospitals and doctors as respective groups. Since doctors were assessed for the maximum amount allowable under the statute, these findings are neither relevant nor material to the issuance of this order.

(9) There is no competent substantial evidence to support Findings of Fact number (25), i.e. that almost *all* of the need for proposed assessments is based on reserves for future payouts and therefore not needed at the present. In any event, §768.54(3)(c) provides that an assessment must be sufficient to meet all claims against the Fund for a particular fund year. Claims were defined at the hearing to include reserves. The Hearing Officer found that the amounts levied as assessments were necessary to meet the claims against the Fund for the years in question.

(10) Findings of Fact numbers (26)-(32) are rejected as being immaterial and irrelevant to these proceedings. The Hearing Officer made the following conclusion in his Recommended Order:

> 4. The Petitioners in this proceeding have not contested the *amount* of the deficits certified by the Fund to the Department for the 1977-1978 and 1978-1979 Fund years. They have, however, contended that the amounts of these deficits might be related to certain managerial practices of the Fund in paying claims, such as exceeding the $100,000 per person, per year payout limitation, and paying excessive amounts for claimants' attorneys' fees. While these practices might appear to be questionable, they are outside the scope of this proceeding, which is limited to determining whether the amounts requested are necessary to meet claims for the years in question, and whether the method of assessment fairly reflects the classifications described in the statutes. It is further concluded, as a matter of law, that the notices of assessments dated February 1, 1982; February 17, 1982; and January 22, 1982, do "fairly reflect" the statutory classifications; that the amounts requested are necessary to meet

claims the procedure used by the Department in spreading liability for these assessments in light of the statutory cap on the liability of physicians, osteopaths and podiatrists is appropriate. The factual findings contained in this order concerning the Fund's claim payment procedures are included only for the purpose of informing the Commissioner of the existence of these practices so that remedial measures if any are deemed necessary, might be taken.

There is therefore no need to adopt Findings of Fact numbers (26)-(32), even if they could be shown to be supported by competent substantial evidence.

(11) Findings of Fact numbers (33)-(39) are not relevant or material and therefore are rejected. Physician members are to be assessed the maximum amount allowable under the statute. The statute contemplates that the balance of the assessments must be levied against the remaining health care providers who were members of the Fund during the respective years. This is true irrespective of what group may be forced to subsidize what group. Findings of Fact as to who is subsidizing who are therefore not relevant or material.

(12) There is no competent substantial evidence to support Findings of Fact numbers (40) and (41). In fact, evidence was presented to the contrary, i.e. that hospitals could revoke the staff privileges of physicians not complying with risk management programs implemented by the hospitals.

(13) Finding of Fact number (42) is not supported by competent substantial evidence. While there was some testimony by one or two hospital administrators that they might have problems paying their hospital's portion of the assessments at that time, it seems highly unlikely that

these hospitals would not be able to pay the assessments today if ordered to do so. These hospitals, which constitute a very small number, have now had time to adequately plan and budget for the assessments and should be able to pay the designated amounts.

(14) Findings of Fact numbers (43) and (44) are based on projections which may or may not prove to be accurate and which are not supported by competent substantial evidence. In any event, these numbers would not change the manner in which the assessments are levied. These findings are therefore rejected as being immaterial and irrelevant.

(15) Finding of Fact number (46) is not relevant or material to the levying of the assessments. The *statute* directs the manner in which the assessments are to be levied irrespective of who ultimately pays. That decision is therefore one that has been made by the Legislature.

(e) The exceptions to the Hearing Officer's Conclusions of Law are rejected. The conclusions of the Hearing Officer are correct and both the conclusions themselves and the rationale therefore have been adopted by this Order. Further response is therefore unnecessary.

DONE and ORDERED this 28th day of July, 1982.

Bill Gunter
Insurance Commissioner
and Treasurer

/s/ Allan J. Katz
Assistant Insurance Commissioner
and Treasurer

(Seal)

(Filed June 22, 1982)

STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

CASE NO. 82-530
CASE NO. 82-776

SOUTHEAST VOLUSIA HOSPITAL DISTRICT, et al.,
Petitioners,

vs.

STATE OF FLORIDA, DEPARTMENT OF INSURANCE and FLORIDA PATIENT'S COMPENSATION FUND,
Respondents.

CASE NO. 82-571

TALLAHASSEE MEMORIAL REGIONAL MEDICAL CENTER, et al.,
Petitioners,

vs.

STATE OF FLORIDA, DEPARTMENT OF INSURANCE and FLORIDA PATIENT'S COMPENSATION FUND,
Respondents.

RECOMMENDED ORDER

Pursuant to notice, the Division of Administrative Hearings, by its duly designated Hearing Officer, William E. Williams, held a formal hearing in this cause on March 30 - April 1, 1982, in Tallahassee, Florida.

APPEARANCES

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and

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and

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and

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By Assessment Notices dated January 22, 1982; February 1, 1982; and February 17, 1982, the State of Florida, Department of Insurance ("Department") proposes to levy assessments pursuant to Section 768.54(3)(c), *Florida Statutes*, on health care providers who were members of the Florida Patient's Compensation Fund ("Fund") for the Fund years 1977-1978 and 1978-1979. This proceeding arises from three separate cases which were consolidated for final hearing. Petitioners in each of these cases are health care providers, as that term is defined in Section 768.54(1), *Florida Statutes*, and have objected to the method by which the Insurance Commissioner ("Commissioner") proposes to levy these assessments.

The final hearing in this cause was scheduled for March 30 - April 1, 1982, by Notice of Hearing dated March 8, 1982. At the final hearing, the Department and the Fund called John W. Odem and Jerome Vogel as their witnesses. The Department offered Respondent Department's Exhibits 1 and 2, and the Fund offered Respondent Fund's Exhibits 1 through 23, each of which was received into evidence. Petitioners called George A. Ruddick, William Schneider, Gilbert G. Wooten, Fred C. Sikes, Tony Dorsey and Robert B. Atkins as their witnesses and offered Petitioners' Exhibits 1 through 12 and 14 through 51, which were received into evidence.

Counsel for all parties submitted proposed findings of fact for consideration by the Hearing Officer in entering this Recommended Order. To the extent that those proposed findings of fact are not contained in this Recommended Order, they have been specifically rejected as being either irrelevant to the issues involved in this proceeding, or as not having been supported by evidence of record.

FINDINGS OF FACT

1. In 1975 the Florida Legislature passed the Medical Malpractice Reform Act, Chapter 75-9, *Laws of Florida*, now codified in Chapter 768, *Florida Statutes*. Part of this legislative package included the creation of the Fund. This legislation was passed in response to a medical malpractice insurance crisis which arose when the primary underwriter for the Florida Medical Association sought to stop issuing medical malpractice policies in Florida, thus making it difficult, if not impossible, for physicians or hospitals to obtain medical malpractice insurance coverage at reasonable rates. As a result of this problem, many physicians began to practice defensive medicine, curtail

or abandon their practices or practice without coverage of any kind.

2. The Fund is a private not-for-profit organization, participation in which is totally voluntary for its member - health care providers. Insofar as Petitioners are concerned, membership in the Fund is but one of several options available to provide legally required evidence of financial responsibility in order to obtain licensure as a hospital facility in Florida. In fact, of the approximately 260 hospitals in Florida, only 125 satisfy their financial responsibility requirement via membership in the Fund. Physicians, hospitals, health maintenance organizations and ambulatory surgical centers who become members of the Fund must maintain at least $100,000 in primary professional liability insurance. Membership in the Fund grants to each participant a limitation of liability above the $100,000 in primary coverage. To the extent that any settlement or judgment exceeds the primary coverage of the participant, it is paid by the Fund without limitation.

3. The Fund is operated subject to the supervision and approval of a board of governors whose membership is required by law to consist of representatives of the insurance industry, the legal and medical professions, physicians' insurers, hospitals, hospitals' insurers and the general public. The Department is charged by statute with certain regulatory functions concerning the Fund. The base fee for Fund membership is set by statute at $500 for physicians, after an initial $1,000 enrollment fee for the first year of participation, and at $300 per bed for hospital members. The statute requires the Department to set additional fees based upon the classifications of health care providers contained in the statute. In the event that base fees are insufficient to pay all claims asserted against the Fund for a given Fund year, the

Department is empowered, upon request of the Board of Governors of the Fund, to order additional assessments against Fund participants to meet any such deficiency.

4. Under the original legislation, all classes of health care providers could be assessed unlimited amounts to make up any deficiencies. As a result of legislative amendments in 1976, however, the amount which participants, other than hospitals, could be assessed was limited to the amount each Fund member had paid to join the Fund for that particular coverage year.

5. 1976 legislative amendments also required that each fiscal year of the Fund be operated independently of preceding fiscal years, and further required that occurrences giving rise to claims in a particular Fund year be paid only from fees or investment income on those fees collected for that particular year. Thus, it is entirely possible for the Fund to experience deficits in a given year, and yet hold surplus funds for other years.

6. The dispute in these consolidated proceedings arises from assessments for deficits incurred for the Fund years 1977-1978 and 1978-1979.

7. Each of the hospitals named as Petitioners in the Petition for Administrative Proceedings in Case No. 82-776 were members of the Fund during the Fund year 1977-1978.

8. Each of the hospitals named in the style and listed on Exhibit "A" to the Amendment to Petition for Adminstrative Proceedings in Case Nos. 82-530 and 82-571 were members of the Fund during the Fund year 1978-1979.

9. On October 31, 1981, the Fund certified to the Department a deficiency in the amount of $1,350,672 for the Fund year 1977-1978. On January 18, 1982, the Fund

certified to the Department an additional deficiency for the Fund year 1977-1978 in the amount of $1,759,591.

10. On January 18, 1982, the Fund certified to the Department a deficiency of $13,935,927 for the Fund year 1978-1979.

11. On January 13, 1982, the Department issued an "order" assessing various classes of health care providers the deficiency originally certified by the Fund for the Fund year 1977-1978.

12. The "order" of January 13, 1982, was amended by the "order" of February 1, 1982, for the Fund year 1977-1978. The amended order contained the same dollar amount of assessments, but altered the amount charged to various classes of Fund members.

13. On February 17, 1982, the Department issued its "order" granting the second assessment for the Fund year 1977-1978.

14. On January 22, 1982, the Department issued its "order" granting the assessment for the 1978-1979 Fund year.

15. The Department has not promulgated any rules pursuant to Chapter 120, *Florida Statutes*, pertaining to its regulation of or duties in conjunction with the Fund under Section 768.54, *Florida Statutes*.

16. As members of the Fund, each of the Petitioners' interests are substantially affected by the Orders of January 13, 1982; January 22, 1982; February 1, 1982; and February 17, 1982.

17. For the Fund year 1977-1978 the total assessment ordered by the Department is $3,110,263.

18. The total assessment for the Fund year 1978-1979 is $13,935,972.

19. For the Fund year 1977-1978, physicians and professional association members are proposed to be assessed $1,730,207.

20. During the Fund year 1977-1978, hospital members paid into the Fund, exclusive of interest earned on the fees, the amount of $5,292,498.

21. For the Fund year 1977-1978, physicians and professional association members paid into the Fund the sum of $2,326,541.

22. For the Fund year 1978-1979, hospital members paid into the Fund, exclusive of interest earned on their fees, the sum of $5,627,553. Interest earned through December 31, 1981, on these fees is $1,725,845.

23. For the Fund year 1978-1979, physicians and professional association members paid into the Fund, exclusive of interest earned on their fees, the sum of $2,411,205. Interest earned through December 31, 1981, on the fees contributed by physicians and professional associations is $739,463.

24. For the Fund year 1977-1978, the proposed assessments against hospital members of the Fund is $1,374,827.

25. For the Fund year 1978-1979, the Fund retained the services of an independent actuarial firm to study and recommend appropriate additional fees to charge its members. The following table reflects the statutory base fees, the fees recommended by the actuary, the fees sought by the Fund and the fees ordered by the Department of Insurance for the 1977-1978 Fund year.

	Base Fees Paid Pursuant to Stat.	Actuary's Recommended Additional Fees	Additional Fees Requested by FPCF	Additional Fees Ordered By DOI
Class I Physicians	$	$	$	$
Dade/Broward Co.	500.00	2,233.00	2,233.00	-0-
Rest of State	500.00	1,749.00	1,749.00	-0-
Class II Physicians				
Dade/Broward Co.	500.00	4,420.00	4,420.00	-0-
Rest of State	500.00	3,549.00	3,549.00	-0-
Class III Physicians				
Dade/Broward Co.	500.00	12,619.00	12,619.00	-0-
Rest of State	500.00	10,297.00	10,297.00	-0-
Hospitals (per occupied bed)	300.00	222.00	222.00	-0-
Ambulatory Surgical Centers (per 100 patients)	-0-	22.00	22.00	-0-
Health Maintenance Organizations (per 100 subscribers)	-0-	150.00	150.00	-0-
Professional Associations	-0-	20% of additional fee to be paid by each individual member	(SAME)	-0-

26. For the Fund year 1978-1979, the Department made no independent actuarial study of the recommended fees proposed by the independent actuary employed by the Fund, and no member of the Casualty Actuarial Society evaluated the Fund's recommendations on behalf of the Department.

27. The independent actuary employed by the Fund was the only actuary who presented any evidence at the hearing conducted by the Department on the Fund's fee increase request for the Fund year 1978-1979.

28. Each year since the Fund year 1977-1978 the Fund has employed the services of an actuary who, among other things, projected the expected losses above the claims previously paid and reserves established for known claims. These expected losses are reported as IBNR ("incurred but not reported") for each Fund year.

29. The IBNR projected by the actuary employed by the Fund in the most recent report (October 1981) for the Fund year 1977-1978 is $6,306,036, and for the Fund year 1978-1979 is $15,965,324.

30. The Department computed the portion of the assessment to be paid by the different classes of health care providers for the Fund year 1977-1978 based upon an approach known as the "indicated rate method." It is concluded from the record that this method is the most feasible of all suggested alternatives under existing law for reflecting the statutory classifications and, at the same time, providing immediate funds necessary to meet all claims against the Fund. This method is represented by the following formula:

(a) The Department started with rates which should have been charged each class in 1981-1982. This is called the "indicated rate by class." (The indicated rates were taken from the October, 1980 report by the Fund actuary.)

(b) The Department then applied the following formula for each class:

Indicated Rate by Class X Number of Members in the Class = Total indicated fees by Class.

Total Indicated Fees by Class ÷ Total Indicated Fees for *ALL* Classes = Percentage of Indicated Fees by Class.

Percentage of Indicated Fee by Class X Total Expected Loss for *ALL* Classes = Expected Loss by Class.

(Expected loss is *all* losses for the fund year included claims previously paid, reserves established on claims asserted and IBNR (incurred but not reported).)

Expected Loss by Class - Actual Fees paid by Class = Potential Loss Assessment by Class.

Potential Loss Assessment by Class ÷ Potential Loss Assessment for *ALL* Classes = Percentage of Potential Loss Assessment by Class.

Percentage of Potential Loss Assessment by Class X Total Assessment to be Ordered by the DOI = Amount of Assessment by Class.

31. The following chart shows the amount each class would have paid under the "indicated rate method" for the Fund year 1977-1978, and the amount actually proposed to be assessed in the "orders" of the Department:

		Indicated Rate Assessment	Actual Assessment
a)	Class I Physicians	$ 146,487.00	$ 138,000.00
b)	Class II Physicians	213,502.00	438,297.00
c)	Class III Physicians	2,198,383.00	813,048.00
d)	Hospitals	521,560.00	1,374,827.00
e)	HMO	614.00	
f)	Surgical Centers	1,381.00	79,953.00
g)	Professional Association	28,336.00	

32. Based upon the "indicated rate method" and based upon the application of Section 768.54, *Florida Statutes*, employed by the Department, assessments for the Fund year 1977-1978 which would otherwise be attributable to physician members of the Fund in the approximate amount of $1,500,000 were not charged to any class of physician.

33. Based upon the "indicated rate method" and based upon the application of Section 768.54, *Florida Statutes*, employed by the Department, assessments for the Fund year 1978-1979 otherwise atttributable to physician members of the Fund in the approximate amount of $9,000,000 were not charged to any class of physicians.

34. The assessments described in the "orders" of the Department for the Fund year 1977-1978 which could not be applied to physician members, based upon the Department's interpretation of Section 768.54, *Florida Statutes*, were spread among the other classes of health care providers based upon their percentage of "expected losses."

35. The Petitioners in this case, each of whom are members of the Fund, consist of 30 government hospitals, 43 private, nonprofit hospitals, and seven private, for-profit hospitals.

36. During the Fund years 1977-1978 and 1978-1979, the Fund consisted of the following classes and numbers of members:

	1977-1978	1978-1979
a) Class I Physicians	1392	1516
b) Class II Physicians	814	971
c) Class III Physicians	1584	1690
d) Hospitals	120	130
e) HMO	2	3
f) Surgical Centers	11	14
g) Professional Associations	572	855

37. The "orders" of the Department dated January 13, 1982; January 22, 1982; February 1, 1982; and February 17, 1982, were the first time any member of the Fund has been assessed under Section 768.54, *Florida Statutes*.

38. The fees paid into the Fund; the investment income earned through December 31, 1981, on such fees; the expenses incurred through December 31, 1981; the amounts paid on claims through December 31, 1981; reserves established through and the IBNR for each Fund year for 1975-1976 through 1980-1981 are reflected on the table on page A67. (IBNR figures are projections of future losses prepared by the Fund's actuary in October 1981.)

39. The rates applicable to physicians and hospital members of the Fund for the years 1977-1878 and 1978-1979 were the base fees provided in Section 768.54, *Florida Statutes*. No additional fees were set for those Fund years.

40. The rate order for the 1978-1979 year entered by the Department on June 9, 1978, was not appealed.

41. The Fund in fact experienced deficits in both Fund years in controversy in this proceeding.

42. The Fund certified to the Department the amount of its projected deficit for the years in question.

43. The amount of money ultimately certified by the Fund to the Department accurately reflects the amounts derived from the following formula:

FUND YEAR:	1975-1976	1976-1977	1977-1978	1978-1979	1979-1980	1980-1981	TOTALS
FEES PAID	$ 2,928,672	$ 6,303,257	$ 7,467,605	$ 8,060,374	$ 9,836,157	$ 11,225,275	$ 45,821,340
INTEREST EARNED	1,475,401	3,000,118	2,592,179	2,543,698	2,589,547	1,882,319	14,083,262
ADMINISTRATIVE EXPENSES	(54,846)	(95,002)	(148,113)	(128,566)	(279,838)	(406,641)	(1,113,006)
NET FUNDS AVAILABLE TO PAY LOSSES	4,349,227	9,208,373	9,911,671	10,475,506	12,145,866	12,700,953	58,791,596
LOSSES PAID TO DATE	(3,004,273)	(6,869,395)	(8,271,696)	(9,760,650)	(3,410,358)	(37,500)	(31,353,872)
INDEMNITY EXPENSES	(300,334)	(343,433)	(391,858)	(532,197)	(206,616)	(32,619)	(1,837,057)
RESERVED LOSSES	(971,731)	(4,249,604)	(3,663,348)	(13,782,271)	(6,445,000)	(3,750,000)	(32,861,956)
RESERVED EXPENSES	(57,584)	(111,466)	(172,869)	(267,932)	(342,787)	(114,417)	(1,067,055)
PRESENT SURPLUS/DEFICIT	(14,697)	(2,365,525)	(2,588,100)	(13,867,544)	1,741,105	8,766,417	(8,328,344)
LOSSES INCURRED NOT YET REPORTED (IBNR) (As of 6-30-81)	$(1,189,136)	$(3,878,887)	$(7,970,235)	$(14,979,237)	$(28,295,428)	$(51,500,564)	$(107,813,487)

Total fees paid during the Fund Year

+ Investment Income attributable to the Fund Year

- Expenses allocated to that Fund Year

- Amount paid on claims for that Fund Year

- Amount reserved for all known claims for that Fund Year.

44. The Department entered orders levying the assessments on January 13, 1982; January 22, 1982; February 1, 1982; and February 17, 1982. The parties to this proceeding stipulated that the assessments entered by the Department for 1977-1978 and 1978-1979 are to be considered to be proposed agency action as to such parties.

45. The Department limited the amount assessed against any physician member to an amount equal to the annual membership fee paid by the physician for the year giving use to the assessment.

46. According to the "orders" of the Department for the Fund year 1977-1978, Class III physicians' share of the assessment, based upon the assessment formula utilized, was in excess of the amount of membership fees paid by that group, and the balance was spread over the rest of the classes of health care providers.

47. According to the "orders" of the Department for the Fund year 1978-1979, Class I, II, and III physicians' share of the assessment, based upon the assessment formula utilized, was in excess of the amount of membership fees paid by those groups, and the balance was spread among those health care providers described in Section 768.54(1)(b)1., 5., 6., and 7., *Florida Statutes*.

48. The Department, by order dated June 9, 1978, denied the Fund's request for additional fees for the year 1978-1979.

49. In April 1981, at the request of the Department, the Fund filed a "Retrospective Rating Plan." This plan provided that at such time as the Fund dropped below 25 percent of the original fees paid in any fund year an assessment would be triggered. The plan further provided for the assessment to be based upon all settlements or final judgments entered but unpaid at the time of the assessment, and all reserves established by the Fund at the time of the assessment.

50. This "Retrospective Rating Plan" was approved by the Department, but not adopted pursuant to Chapter 120, *Florida Statutes*. Although the Fund sought to amend the plan both before and after the assessments now at issue, the original plan remained in effect at all times material to this cause.

51. Although Petitioners have not disputed the amount of the reserves set by the Fund, such reserves constitute a substantial portion of the assessment amounts requested by the Fund. The Department has not made any evaluation of the accuracy of the case reserves, nor has the Department made any analysis of the method employed by the Fund in setting case reserves.

52. There was some evidence that the cash shortages experienced by the Fund for the Fund years 1977-1978 and 1978-1979 may have been caused in part by the manner in which the Fund has paid claims. In 1976 the Florida Legislature limited the amount which the Fund could pay out on claims to $100,000 per person, per year. In addition, the law provides that reasonable attorneys' fees and costs shall be paid to a successful claimant within the first 90 days following a judgment or settlement.

53. In most instances, the Fund does not inquire into the fee arrangement between plaintiffs and their attorneys. Moreover, no claim for attorneys' fees is required to be submitted to the Fund or the trial court to set a reasonable fee for such services. The Fund has indicated that for claims paid for the Fund years 1977-1978 and 1978-1979, the Fund simply assumed that attorneys' fees and costs equalled 40 percent of the amount of the settlement or judgment. In most cases, the Fund does not consider any portion of the attorneys' fees as having been paid by the primary insurance carrier.

54. In some instances, it appears that payments made by the Fund may have disregarded the $100,000 per person, per year payout limitation, and in other instances the Fund has been ordered to pay amounts in excess of the statutory limit and has not pursued an appeal of such orders. In still other instances the Fund has purchased annuities to fund settlements or judgments, the cost of which annuities exceeded the $100,000 payout limitation. The Fund does not consider such payments to be subject to the payout limitation although no rights of ownership in the annuities are retained by the Fund.

55. It is possible that the cumulative effect of these practices has been significant. Petitioners adduced evidence estimating "excess payments" by the Fund for 1977-1978 over the statutory limit could be as high as $2,684,737. For the Fund year 1978-1979 these "excess payments" could be as high as $4,827,690.

56. Under the Department's application of Section 768.54, *Florida Statutes*, no physician member will again be assessed for the Fund years 1977-1978 and 1978-1979. Yet, based upon the latest estimates by the Fund's consulting actuary, additional claims for those two years which

have not yet been reported could reach as high as $22,949,472. Under the Department's construction of the statute, hospital members will have to pay all of these additional losses, if the actuary's projections prove correct.

CONCLUSIONS OF LAW

1. The Division of Administrative Hearings has jurisdiction over the subject matter of and the parties to this proceeding. Section 120.57(1), *Florida Statutes.*

2. Section 768.54(3)(c), *Florida Statutes,* which governs the imposition of fees and assessments by the Fund, provides in pertinent part as follows:

> Annually, each health care provider, as set forth in subsection (2), electing to comply with paragraph (2)(b) shall pay the fees established under this act, for deposit into the fund, which shall be remitted for deposit in a manner prescribed by the Insurance Commissioner. The limitation of liability provided by the fund shall begin July 1, 1975, and run thereafter on a fiscal-year basis. For the first year of membership, each participating health care provider shall pay a base fee for deposit into the fund in the amount of $1,000 for any individual, or $300 per bed for any hospital. Those entering the fund after the fiscal year has begun shall pay a prorated share of the yearly fees for a prorated membership. The base fee charged after the first year of participation shall be $500 for any individual, or $300 per bed for any hospital . . . In addition, after the first year of operation, additional fees may be charged but shall be appropriately prorated for the portion of the year for which the health care provider participated in the fund, based on the following considerations:

(1) Past and prospective loss and expense experience in different types of practice and in different geographical areas within the state;

(2) The prior claims experience of the member covered under the fund; and

(3) Risk factors for persons who are retired, semi-retired, or part-time professionals.

Such base fees may be adjusted downward for any fiscal year in which a lesser amount would be adequate and in which the additional fee would not be necessary to maintain the solvency of the fund. Such additional fee shall be based on not more than two geographical areas with three categories of practice and with categories which contemplate separate risk ratings for hospitals, for health maintenance organizations, for ambulatory surgical facilities, and for other medical facilities. Each fiscal year of the fund shall operate independently of preceding fiscal years. Participants shall only be liable for assessments for claims from years during which they were members of the fund . . . The fund shall be maintained at not more than $15,000,000 per fiscal year. Additional fees, *assessments,* or refunds *shall be set by the Insurance Commissioner after consultation with the board of governors of the fund . . . If the fund determines that the amount of money in an account for a given fiscal year is in excess of or not sufficient to satisfy the claims made against the account, the fund shall certify the amount of the projected excess or insufficiency to the Insurance Commissioner and request the Insurance Commissioner to levy an assessment* against or refund to all participants in the fund for that fiscal year, prorated, based on the number of days of par-

ticipation during the year in question. The Insurance Commissioner shall order such refund to, or levy such assessment against, such participants *in amounts that fairly reflect the classifications prescribed above and are sufficient to obtain the money necessary to meet all claims for said fiscal year. In no case shall any assessment for a particular year against any health care provider, other than those health care providers defined in subparagraphs (1)(b) 1., 5., 6., and 7., exceed an amount equal to the fees originally paid by such health care provider for participation in the fund for the year giving rise to such assessment.* (Emphasis is added.)

3. The above-quoted statute provides the Fund with three mechanisms to obtain monies with which to operate: "base" fees; "additional" fees; and "assessments." The amount of "base" fees that may be charged physicians and hospitals are set by statute at $1,000 for the first year and $500 for subsequent years insofar as physician members are concerned, and $300 per bed for hospital participants. There appears to be no upper limit on the amount of "additional" fees which might be charged members of the Fund, so long as the criteria contained in the statute for imposing such fees are met. With respect to "assessments," however, the 1976 Legislature amended Section 768.54(3)(c) to prohibit any assessment against physicians, osteopaths and podiatrists from exceeding the membership fees paid for the year giving rise to the assessment. It is specifically concluded, as a matter of law, that this amendment imposed a "cumulative" cap on the liability of physicians, osteopaths and podiatrists for assessments for deficits for a given coverage year, so that those participants are liable only for a maximum of either $1,000 or $500 in assessments, depending upon whether the year

in question was their first year or a subsequent year of participation in the Fund.

4. The Petitioners in this proceeding have not contested the *amount* of the deficits certified by the Fund to the Department for the 1977-1978 and 1978-1979 Fund years. They have, however, contended that the amounts of these deficits might be related to certain managerial practices of the Fund in paying claims, such as exceeding the $100,000 per person, per year payout limitation, and paying excessive amounts for claimants' attorneys' fees. While these practices might appear to be questionable, they are outside the scope of this proceeding, which is limited to determining whether the amounts requested are necessary to meet claims for the years in question, and whether the method of assessment fairly reflects the classifications described in the statutes. It is further concluded, as a matter of law, that the notices of assessments dated February 1, 1982; February 17, 1982; and January 22, 1982, do "fairly reflect" the statutory classifications; that the amounts requested are necessary to meet claims against the Fund for the years in question; and that the procedure used by the Department in spreading liability for these assessments in light of the statutory cap on the liability of physicians, osteopaths and podiatrists is appropriate. The factual findings contained in this order concerning the Fund's claim payment procedures are included only for the purpose of informing the Commissioner of the existence of these practices so that remedial measures, if any are deemed necessary, might be taken.

Accordingly, based upon the foregoing Findings of Fact and Conclusions of Law, it is

RECOMMENDED:

That a final order be entered by the Department of Insurance levying assessments in accordance with the notices of assessment dated February 1, 1982; February 17, 1982; and January 22, 1982, for the Fund years 1977-1978 and 1978-1979.

DONE AND ENTERED this 22nd day of June, 1982, in Tallahassee, Florida.

/s/ William E. Williams
Hearing Officer
Division of Administrative Hearings
Oakland Building
2009 Apalachee Parkway
Tallahassee, Florida 32301
(904) 488-9675

FILED with the Clerk of the Division of Administrative Hearings this 22nd day of June, 1982.

• • •

SECTION 768.54, FLORIDA STATUTES (1977)

[1]768.54 Limitation of liability and patient's compensation fund.—

(1) DEFINITIONS.—The following definitions apply in the interpretation and enforcement of this section:

(a) "Fund" means the Florida Patient's Compensation Fund.

(b) "Health care provider" means any:

1. Hospital licensed under chapter 395.

2. Physician licensed, or physician's assistant certified, under chapter 458.

3. Osteopath licensed under chapter 459.

4. Podiatrist licensed under chapter 461.

5. Health maintenance organization certificated under part II of chapter 641.

6. Ambulatory surgical center, as defined in paragraph (c).

7. Professional association, partnership, corporation, joint venture, or other association by the individuals set forth in subparagraphs 2., 3., and 4. for professional activity.

(c) "Ambulatory surgical center" means a facility the primary purpose of which is to provide elective surgical care or diagnostic or medical care or treatment, in which the patient is admitted to and discharged from said facility within the same working day, and which is not part of a hospital. However, a facility existing for the primary purpose of performing terminations of pregnancy, or an office

maintained by a physician or dentist for the practice of medicine, shall not be construed to be an ambulatory surgical center.

(d) "Hospital" means a hospital licensed under chapter 395.

(e) "Health maintenance organization" means any health maintenance organization certificated under part II of chapter 641.

(2) LIMITATION OF LIABILITY.—

(a) All hospitals shall, unless exempted under paragraph (c), and all health care providers other than hospitals may, prior to practicing or operating during any fiscal year of the fund, pay the yearly fee and assessment or, in cases in which such hospital or health care provider joined the fund after the fiscal year had begun, a prorated assessment into the fund pursuant to subsection (3).

(b) A health care provider shall not be liable for an amount in excess of $100,000 per claim for claims covered under subsection (3) in this state if, at the time the incident giving rise to the cause of the claim occurred, the health care provider:

1. Had:

a. Posted bond in the amount of $100,000 per claim;

b. Proved financial responsibility in the amount of $100,000 per claim to the satisfaction of the board of governors of the fund through the establishment of an appropriate escrow account;

c. Obtained medical malpractice insurance in the amount of $100,000 or more per claim from private insurers or the Joint Underwriting Association established under subsection 627.351(7); or

d. Obtained self-insurance as provided in s. 627.357, providing coverage in an amount of $100,000 or more per claim, and

2. Had paid, for the year in which the incident occurred for which the claim was filed, the fee required pursuant to subsection (3).

(c) Any hospital that can meet one of the following provisions demonstrating financial responsibility to pay claims and costs ancillary thereto arising out of the rendering of medical care or services in this state shall not be required to participate in the fund:

1. Post bond in an amount equivalent to $10,000 per claim for each hospital bed in said hospital, not to exceed a $2,500,000 annual aggregate;

2. Prove financial responsibility in an amount equivalent to $10,000 per claim for each hospital bed in said hospital, not to exceed a $2,500,000 annual aggregate, to the satisfaction of the board of governors of the fund, through the establishment of an appropriate escrow account;

3. Obtain professional liability coverage in an amount equivalent to $10,000 or more per claim for each bed in said hospital from a private insurer, from the Joint Underwriting Association established under subsection 627.351(7), or through a plan of self-insurance as provided in s. 627.357; however, no hospital shall be required to obtain such coverage in an amount exceeding a $2,500,000 annual aggregate.

(d)1. Any health care provider who does not participate in the fund, or participates and does not meet the provisions of paragraph (b), shall be subject to liability under law without regard to the provisions of this section.

2. Annually, the Department of Health and Rehabilitative Services shall require certification by each hospital that said hospital is in compliance, and shall remain in compliance, with the provisions of this section. The license of any hospital not in compliance, or failing to remain in compliance, with the provisions of this section, or of any hospital failing to provide such certification, shall be revoked or suspended by said department.

(c) The limitation of liability and coverage afforded by the fund for a participating hospital or ambulatory surgical center shall apply to the officers, trustees, volunteer workers, and employees of the hospital or ambulatory surgical center, other than employed physicians licensed under chapter 458 who are not in a resident training program, physician's assistants licensed under chapter 458, osteopaths licensed under chapter 459, dentists licensed under chapter 466, and podiatrists licensed under chapter 461.

(3) PATIENT'S COMPENSATION FUND.—

(a) *The fund.*—There is created a "Florida Patient's Compensation Fund," hereinafter referred to as the "fund," for the purpose of paying that portion of any medical malpractice claim for health care providers, or [2][claim] for bodily injury or property damage to the person or property of any patient arising out of the insureds' activities for those health care providers set forth in subparagraphs (1)(b)1., 5., and 6., which is in excess of the limits as set forth in paragraph (2)(b). The fund shall be liable only for payment of claims against health care providers who are in compliance with the provisions of paragraph (2)(b), [2][of] reasonable and necessary expenses incurred in the payment of claims, and [2][of] fund administrative expenses.

(b) *Fund administration and operation.*—Management of the fund shall be vested with the Joint Underwriting Association authorized by subsection 627.351(7), hereinafter referred to as the "JUA." The JUA shall operate subject to the supervision and approval of a board of governors consisting of representatives of five of the insurers participating in the JUA, an attorney to be named by the Florida Bar, a physician to be named by the Florida Medical Association, a hospital representative to be named by the Florida Hospital Association, and the Insurance Commissioner or his designated representative employed by the Department of Insurance. The Insurance Commissioner or his representative shall be the chairman of the board. In the event of termination or dissolution of said JUA with respect to providing professional liability [2][insurance], malpractice [2][insurance], or insurance for bodily injury or property damage to the person or property of any patient arising out of the insureds' activities, the JUA shall continue to operate for the purpose of fund management as provided in this subsection.

(c) *Fees and assessments.*—Annually, each health care provider, as set forth in subsection (2), electing to comply with paragraph (2)(b) shall pay the fees established under this act, for deposit into the fund, which shall be remitted for deposit in a manner prescribed by the Insurance Commissioner. The coverage provided by the fund shall begin July 1, 1975, and run thereafter on a fiscal year basis. For the first year of participation, each participating health care provider covered under the fund shall pay a fee for deposit into the fund in the amount of $1,000 for any individual, or $300 per bed, for any hospital. Those entering the fund after the fiscal year has begun shall pay a prorated share of the yearly fees for a prorated membership. The fee charged after the first year

of participation shall consist of a base fee of $500 for any individual, or $300 per bed, for any hospital. The fees or assessments to be paid by those health care providers defined in subparagraphs (1)(b)5., 6., and 7. shall be established by the fund on an actuarially sound basis. In addition, after the first year of operation, additional fees shall be assessed, appropriately prorated for the portion of the year for which the health care provider participated in the fund, based on the following considerations:

1. Past and prospective loss and expense experience in different types of practice and in different geographical areas within the state;

2. The prior claims experience of the members covered under the fund; and

3. Risk factors for persons who are retired, semiretired, or part-time professionals.

Said base fees may be adjusted downward for any fiscal year in which a lesser amount would be adequate and in which the additional fee would not be necessary to maintain the solvency of the fund. Said additional fee shall be based on not more than two geographical areas with three categories of practice and with categories which contemplate individual risk ratings for hospitals, for health maintenance organizations, and for ambulatory surgical facilities. Each fiscal year of the fund shall operate independently of preceding fiscal years. Participants shall only be liable for assessments for claims from years during which they were members of the fund; in cases in which a participant is a member of the fund for less than the total fiscal year,[3] [the participant] shall be subject to assessments for that year on a prorata basis determined by the percentage of the year[3] [the participant] participated. The fund shall be maintained at not more than

$25,000,000 per fiscal year. Fees and refunds shall be set by the Insurance Commissioner after consultation with the JUA. Nothing contained herein shall be construed as imposing liability for payment of any part of a fund deficit on the JUA or its member insurers. If the fund determines that the amount of money in an account for a given fiscal year is not sufficient to satisfy the claims made against the account, the fund shall certify the amount of the projected insufficiency to the Insurance Commissioner and request the Insurance Commissioner to levy a deficit assessment against all participants in the fund for that fiscal year, prorated, based on the number of days of participation during the year in question. The Insurance Commissioner shall order such refund to, or levy such deficit assessment against, such participants in amounts that fairly reflect the classifications prescribed above and are sufficient to obtain the money necessary to meet all claims for said fiscal year. In no case shall any deficit assessment for a particular year against any health care provider other than a hospital exceed an amount equal to the fees or assessments originally paid by such health care provider for participation in the fund for the year giving rise to such deficit assessment.

(d) *Fund accounting and audit.*—

1. Moneys shall be withdrawn from the fund only upon vouchers approved by the JUA as authorized by the board of governors.

2. All books, records, and audits of the fund shall be open for reasonable inspection to the general public, except that a claim file in possession of the fund shall not be available for review during processing of that claim.

3. Persons authorized to receive deposits, issue vouchers, or withdraw or otherwise disburse any fund moneys

shall post a blanket fidelity bond in an amount reasonably sufficient to protect fund assets. The cost of such bond shall be paid from the fund.

4. Annually, the fund shall furnish, upon request, audited financial reports to any fund participant and to the Department of Insurance and the Joint Legislative Auditing Committee. The reports shall be prepared in accordance with accepted accounting procedures and shall include income and such other information as may be required by the Department of Insurance or the Joint Legislative Auditing Committee.

5. Moneys held in the fund shall be invested in interest-bearing investments by the JUA as administrator. However, in no case shall said moneys be invested for longer than 3 years or in the stock of any insurer participating in the JUA or in the parent company or company owning a controlling interest of said insurer. All income derived from such investments shall be credited to the fund.

6. Any health care provider participating in the fund may withdraw from such participation only at the end of a fiscal year; however, such health care provider shall remain subject to any deficit assessment or any refund pertaining to any year in which such person or hospital participated in the fund.

(e) *Claims procedures.*—

1. Any person may file an action against a participating health care provider for damages covered under the fund, except that the person filing the claim shall not recover against the fund for any portion of a judgment for damages arising out of the rendering of, or failure to render, medical care or services against a health care provider for damages covered under the fund unless the

fund was named as a defendant in the suit. The fund is not required to actively defend a claim until the provisions of s. 768.44 are completed or waived, suit instituted, and the fund is named therein. If, after the facts upon which the claim is based are reviewed, it appears that the claim will exceed $100,000 or, if greater, the amount of the health care provider's basic coverage, the fund shall appear and actively defend itself when named as a defendant in the suit. In so defending, the fund shall retain counsel and pay out of the account for the appropriate year attorneys' fees and expenses, including court costs incurred in defending the fund. In any claim the attorney or law firm retained to defend the fund shall not be retained to defend the JUA. The fund is authorized to negotiate with any claimants having a judgment exceeding $100,000 cost to the fund to reach an agreement as to the manner in which that portion of the judgment exceeding that $100,000 cost is to be paid. Any judgment affecting the fund may be appealed under the Florida Appellate Rules of Procedure, as with any defendant.

2. It shall be the responsibility of the insurer or self-insurer providing insurance or self-insurance for a health care provider who is also covered by the fund to provide an adequate defense on any claim filed which potentially affects the fund, with respect to such insurance contract or self-insurance contract. The insurer or self-insurer shall act in a fiduciary relationship toward the fund with respect to any claim affecting the fund. No settlement exceeding $100,000, or any other amount which could require payment by the fund, shall be agreed to unless approved by the fund.

3. A person who has recovered a final judgment or a settlement approved by the fund against a health care provider who is covered by the fund may file a claim

with the fund to recover that portion of such judgment or settlement which is in excess of $100,000 or the amount of the health care provider's basic coverage, if greater, as set forth in paragraph (2)(b). In the event an account for a given year incurs liability exceeding $100,000 to all persons under a single occurrence, the persons recovering shall be paid from the account at a rate not more than $100,000 per person per year until the claim has been paid in full, except that court costs and reasonable attorney's fees shall be paid in one lump sum within 90 days after the settlement or judgment is rendered. Such fees shall not reduce the amount of the annual award.

4. Settlements or judgments against the fund shall be paid in the order received within 90 days after the date of settlement or judgment, unless appealed by the fund. If the account for a given year does not have enough money to pay all of the settlements or judgments, those claims received after the funds are exhausted shall be immediately payable from the assessments of participants for that year, in the order in which they were received.

5. If a health care provider participating in the fund has coverage in excess of $100,000 per claim, such health care provider shall be liable for losses up to the amount of his coverage, and such health care provider shall receive an appropriate reduction of the fees and assessments for participation in the fund. Such reduction shall be granted only after that health care provider has proved to the satisfaction of the fund that such health care provider had such coverage during the period of membership of the fiscal year.

6. The manager of the JUA or his assistant is the agent for service of process for the plan.

History.—s. 15, ch. 75-9; s. 3, ch. 76-168; s. 6, ch. 76-260; s. 4, ch. 77-64; s. 1, ch. 77-174.

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[1]Note.—Repealed by s. 3, ch. 76-168, effective July 1, 1982.

[2]Note.—Bracketed word inserted by the editors.

[3]Note.—Bracketed words substituted by the editors for "he."

Note.—Former s. 627.353.

CHAPTER 75-9, LAWS OF FLORIDA (EXCERPTS)

CHAPTER 75-9

House Bill No. 1267

AN ACT relating to medical liability insurance and civil law revisions concerning medical malpractice actions; providing a short title; creating s. 627.352, Florida Statutes, relating to the creation of a medical liability insurance study commission; creating s. 395.18, Florida Statutes, authorizing certain hospitals to establish internal risk management programs; amending subsection (1) of s. 627.355, Florida Statutes, to allow total self-insurance by a group or association of physicians or health care facilities organized for any purpose; creating s. 768.133, Florida Statutes, providing for the establishment of medical liability mediation panels in each judicial circuit; providing for the filing, hearing and disposition of claims, and providing a filing fee; providing for legal proceedings subsequent to the decision of the mediation panels; amending s. 95.11(4), Florida Statutes, 1974 Supplement, relating to the statute of limitations, to provide that actions for medical malpractice shall be commenced within two years from the time the incident occurred or the injury is discovered but not to exceed four years from the date the incident occurred; providing exceptions for fraud and misrepresentation; creating s. 768.042, Florida Statutes, to prohibit the stating of the amount of general damages in any complaint for recovery of damages for personal injury or wrongful death; amending s. 725.01, Florida Statutes, to provide that medical guarantees shall be governed by the Statute of Frauds;

creating s. 768.132, Florida Statutes, entitled the "Florida Medical Consent Law" covering consent in all cases not covered by s. 768.13, Florida Statutes, entitled the Good Samaritan Act"; setting standards for information necessary for consent; providing a presumption where a valid consent was given; amending s. 458.1201 (1)(m), Florida Statutes, and adding paragraphs (o) and (p) to said section; providing that the State Board of Medical Examiners determine standards of acceptable and prevailing medical practice; authorizing board action in medical malpractice cases and certain disciplinary cases; providing for a civil penalty; adding paragraphs (c) and (d) to s. 458.1201(2), Florida Statutes; providing for appointment of licensed physicians to act for the board; providing for immunity from liability for investigations conducted pursuant to this act; amending s. 458.1201(3)(a), Florida Statutes; authorizing board to require physicians to participate in continuing education programs; authorizing board to require physicians to practice under the direction of a physician in certain locations; adding s. 458.1201(5), Florida Statutes; requiring the board to report to the legislature; creating s. 395.065, Florida Statutes, providing for hospital disciplinary powers; adding subsection (8) to s. 627.351, Florida Statutes, to provide for a joint underwriting plan offering medical malpractice insurance coverage to be set up by the Department of Insurance and underwritten by insurers writing casualty insurance as defined in s. 624.605(1)(b), (j), and (p), Florida Statutes, and self-insurers authorized under s. 627.355, Florida Statutes; creating s. 627.353, Florida Statutes, to provide for the limitation of liability when certain provisions are met for any licensed hospital, physician, physician's assistant, osteopath or podiatrist for the amount of any settlement

approved by the joint underwriting association established under s. 627.351(8), Florida Statutes, or any judgment exceeding $100,000 for any claim arising out of the rendering of medical care or services; creating a patient's compensation fund to be administered by said joint underwriting association subject to supervision by a board of governors to provide coverage for the amount of any such settlement or judgment affected by said limitation of liability; providing for fees to support the fund including an assessment against participants for deficits; providing for costs in administering or defending the fund; providing claims procedures; providing an effective date.

WHEREAS, the cost of purchasing medical professional liability insurance for doctors and other health care providers has skyrocketed in the past few months; and

WHEREAS, it is not uncommon to find physicians in high-risk categories paying premiums in excess of $20,000 annually; and

WHEREAS, the consumer ultimately must bear the financial burdens created by the high cost of insurance; and

WHEREAS, without some legislative relief, doctors will be forced to curtail their practices, retire, or practice defensive medicine at increased cost to the citizens of Florida; and

WHEREAS, the problem has reached crisis proportion in Florida, NOW THEREFORE,

Be It Enacted by the Legislature of the State of Florida:

Section 1. The short title of this act shall be "The Medical Malpractice Reform Act of 1975".

• • •

Section 15. Section 627.353, Florida Statutes, is created to read:

627.353 Limitation of liability and patient's compensation fund.—

(1) LIMITATION OF LIABILITY.—

(a) All hospitals licensed under chapter 395, Florida Statutes, shall, unless exempted under paragraph (c) of this section, and all physicians and physician's assistants licensed under chapter 458, Florida Statutes, osteopaths licensed under chapter 459, Florida Statutes, and podiatrists licensed under chapter 461, Florida Statutes, may, pay the yearly assessment into the patient's compensation fund pursuant to subsection (2) of this section prior to practicing during any year.

(b) Said licensed hospital, physician, physician's assistant, osteopath, or podiatrist shall not be liable for an amount in excess of $100,000 for claims arising out of the rendering of medical care or services in this state if at the time the incident occurred giving rise to the cause of the claim the hospital, physician, physician's assistant, osteopath or podiatrist:

1. had posted bond in the amount of $100,000, proved financial responsibility in the amount of $100,000 to the satisfaction of the Insurance Commissioner through the establishment of an appropriate escrow account, obtained medical malpractice insurance in the amount of $100,000 or more from private insurers or the joint underwriting association established under section 14 of this act, or obtained self-insurance as provided in s. 627.355, Florida Statutes, providing coverage in an amount of $100,000 or more, and

2. Had paid for the year in which the incident occurred for which the claim was filed the fee required pursuant to subsection (2) of this section.

(c) Any hospital that can meet one of the following provisions demonstrating financial responsibility to meet claims arising out of the rendering of medical care or services in this state shall not be required to participate in the fund:

1. Post bond in an amount equivalent to $10,000 for each hospital bed in said hospital not to exceed $2,500,000; or

2. Prove financial responsibility in an amount equivalent to $10,000 for each hospital bed in said hospital not to exceed $2,500,000 to the satisfaction of the Insurance Commissioner through the establishment of an appropriate escrow account; or

3. Obtain professional liability coverage in an amount equivalent to $10,000 or more for each bed in said hospital from a private insurer, from the joint underwriting association established under section 14 of this act, or through a plan of self-insurance as provided in s. 627.355, Florida Statutes; provided, however, no hospital shall be required to obtain such coverage in an amount exceeding $2,500,000.

(d) Any licensed hospital, physician, physician's assistant, osteopath, or podiatrist who does not meet the provisions of paragraph (b) of this subsection shall be subject to liability under law without regard to the provisions of this section.

(2) PATIENT'S COMPENSATION FUND.—

(a) The fund.—There is created a "Florida Patient's Compensation Fund" hereinafter referred to as the "Fund",

for the purpose of paying that portion of any medical malpractice claim which is in excess of $100,000 as set forth in paragraph (b) of subsection (1) of this section. The Fund shall be liable only for payment of claims against hospitals, physicians, physician's assistants, osteopaths and podiatrists in compliance with the provisions of paragraph (b) of subsection (1) of this section, and reasonable and necessary expenses incurred and payment of claims and fund administrative expenses.

(b) Fund administration and operation.—Management of the fund shall be vested with the joint underwriting association authorized by section 14 of this act, hereinafter referred to as the JUA. The JUA shall operate subject to the supervision and approval of a board of governors consisting of representatives of five of the insurers participating in the JUA an attorney to be named by the Florida Bar, a physician to be named by the Florida Medical Association, a hospital representative to be named by the Florida Hospital Association, and the Insurance Commissioner or his designated representative employed by the Department of Insurance. The Insurance Commissioner or his representative shall be the chairman of the board. In the event of termination or dissolution of said JUA with respect to providing professional liability or malpractice insurance, the JUA shall continue to operate for the purpose of fund management as provided in this subsection.

(c) Fees and assessments.—Annually, each licensed hospital, physician, physician's assistant, osteopath or podiatrist as set forth in subsection (1) electing to comply with paragraph (b) of subsection (1) of this section shall pay the fees established under this act for deposit into the fund, which shall be remitted for deposit in a manner prescribed by the Insurance Commissioner. The coverage provided by the fund shall begin July 1, 1975 and run

thereafter on a fiscal year basis. For the first year of operation each participating licensed hospital, physician, physician's assistant, osteopath, or podiatrist covered under the fund shall pay a fee for deposit into the fund in the amount of $1,000 for any individual and $300 per bed for any hospital. The fee charged after the first year of operation shall consist of a base fee of $500 for any individual and $300 per bed for any hospital. In addition, after the first year of operation additional fees shall be assessed based on the following considerations:

1. Past and prospective loss and expense experience in different types of practice and in different geographical areas within the state.

2. The prior claims experience of persons or hospitals covered under the fund.

3. Risk factors for persons who are retired, semi-retired or part-time professionals.

Said base fees may be adjusted downward for any fiscal year in which a lesser amount would be adequate and in which the additional fee would not be necessary to maintain the solvency of the fund. Said additional fee shall be based on not more than two geographical areas with three categories of practice and with a fourth category which contemplates individual risk rating for hospitals. The fund shall be maintained at not more than $25,000,000. Fees shall be set by the Insurance Commissioner after consultation with the JUA. Nothing contained herein shall be construed as imposing liability for payment of any part of a fund deficit on the JUA or its member insurers. If the JUA determines that the amount of money in the fund is not sufficient to satisfy the claims made against the fund in a given fiscal year, the JUA shall certify the amount of the projected insufficiency to the

Insurance Commissioner and shall request the Insurance Commissioner to levy a deficit assessment against all participants in the fund for that fiscal year. The Insurance Commissioner shall levy such deficit assessment against such participants in amounts that fairly reflect the classifications prescribed above and which are sufficient to obtain the money necessary to meet all claims for said fiscal year.

(d) *Fund accounting and audit.—*

1. Monies shall be withdrawn from the fund only upon vouchers approved by the JUA as authorized by the Board of Governors.

2. All books, records, and audits of the fund shall be open for reasonable inspection to the general public.

3. Persons authorized to receive deposits, withdraw, issue vouchers or otherwise disburse any fund monies shall post a blanket fidelity bond in an amount reasonably sufficient to protect fund assets. The cost of such bond shall be paid from the fund.

4. Annually, the JUA shall furnish an audited financial report to all fund participants and to the Department of Insurance and to the Joint Legislative Auditing Committee. The report shall be prepared in accordance with accepted accounting procedures and shall include income and such other information as may be required by the Department of Insurance or the Joint Legislative Auditing Committee.

5. Monies held in the fund shall be invested in short-term interest bearing investments by the JUA as administrator, provided that in no case shall said moneys be invested in the stock of any insurer participating in the JUA or in the parent company or company owning a con-

trolling interest of said insurer. All income derived from such investments shall be credited to the fund.

6. Any person or hospital participating in the fund may withdraw from such participation at the end of any fiscal year; however, such person or hospital shall remain subject to any deficit assessment pertaining to any year in which such person or hospital participated in the fund.

(e) Claims procedures.—

1. Any person may file an action for damages arising out of the rendering of medical care or services against a person covered under the fund provided that the person filing the claim shall not recover against the fund any portion of a judgment for damages arising out of the rendering of medical care or services against a person covered under the fund unless the fund was named as a defendant in the suit. If after reviewing the facts upon which the claim is based it appears that the claim will exceed $100,000, the fund shall appear and actively defend itself when named as a defendant in the suit. In so defending, the fund shall retain counsel and pay out of the fund attorneys's fees and expenses including court costs incurred in defending the fund. The attorney or law firm retained to defend the fund shall not be retained or employed by the JUA to perform legal services for the JUA other than those directly connected with the fund. The fund is authorized to negotiate with any claimants having a judgment exceeding $500,000 to reach an agreement as to the manner in which that portion of the judgment exceeding $500,000 is to be paid. Any judgment affecting the fund may be appealed under the Florida Appellate Rules of Procedure as with any defendant.

2. It shall be the responsibility of the insurer or self-insurer providing insurance or self-insurance for a hospital,

physician, physician's assistant, osteopath or podiatrist who is also covered by the fund to provide an adequate defense on any claim filed that potentially affects the fund with respect to such insurance contract or self-insurance contract. The insurer shall act in a fiduciary relationship with respect to any claim affecting the fund. No settlement exceeding $100,000, or any other amount which could require payment by the fund, shall be agreed to unless approved by the JUA.

3. A person who has recovered a final judgment or a settlement approved by the JUA against a hospital, physician, physician's assistant, osteopath or podiatrist, who is covered by the fund may file a claim with the JUA to recover that portion of such judgment or settlement which is in excess of $100,000 as set forth in paragraph (b) of subsection (1) of this section. In the event the fund incurs liability exceeding $1,000,000 to any person under a single occurrence the fund shall pay not more than $1,000,000 per year until the claim has been paid in full.

4. Claims filed against the fund shall be paid in the order received with 90 days after filing unless appealed by the fund. If the fund does not have enough money to pay all of the claims, claims received after the funds are exhausted shall be immediately payable the following year in the order in which they were received.

5. If a person or hospital participating in the fund has coverage in excess of $100,000, he shall be liable for losses up to the amount of his coverage, and he shall receive an appropriate reduction of his assessment for the fund. Such reduction shall be granted only after that person has proved to the satisfaction of the JUA that he has such coverage.

* * *

(Filed November 21, 1983)

IN THE SUPREME COURT OF FLORIDA

Case No. 63,693

DEPARTMENT OF INSURANCE, STATE OF FLORIDA, et al., Appellants,

v.

SOUTHEAST VOLUSIA HOSPITAL DISTRICT, et al., Appellees.

Case Nos. 63,699 & 63,751
District Court of Appeal, 1st District -
Nos. AN-412 & AN-367
CONSOLIDATED CASES

FLORIDA PATIENT'S COMPENSATION FUND, et al., Appellants,

v.

SOUTHEAST VOLUSIA HOSPITAL DISTRICT, et al., Appellees.

NOTICE OF APPEAL TO THE SUPREME COURT OF THE UNITED STATES

Notice is hereby given that Southeast Volusia Hospital District, Highlands County Hospital District, and the other hospital appellees on the attached list, the appellees above-named, hereby appeal to the Supreme Court of the United States from the final judgment of the Supreme Court of Florida sustaining the constitutionality of Section 768.54, Florida Statutes which was entered in this action on June 9, 1983, as explained in the opinion of the Supreme Court of Florida dated September 15, 1983, with the timely

petition for rehearing of the final judgment, as explained, being denied on November 4, 1983.

This appeal is taken pursuant to Title 28, United States Code, Section 1257(2).

Dated: September 21, 1983.

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By /s/ Neil H. Butler
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By /s/ J. Robert McClure, Jr.
J. Robert McClure, Jr.

CERTIFICATE OF SERVICE

I, J. Robert McClure, Jr. of Carlton, Fields, Ward, Emmanuel, Smith and Cutler, P.A. and a member of the Bar of the Supreme Court of the United States and counsel of record for Highlands County Hospital District, among other appellees herein, hereby certify that on November 21, 1983, pursuant to Rule 33, Rules of the United States Supreme Court, I served a true and correct copy of the foregoing notice of appeal on each of the parties herein, as follows:

On the Florida Department of Insurance, one of the appellants herein, by depositing such copy in the United States Post Office, Tallahassee, Florida, with first class postage prepaid, properly addressed to David A. Yon, the above named appellant's counsel of record, at 428-A Larson Building, Tallahassee, Florida 32301; and

On the Florida Patient's Compensation Fund, one of the appellants herein, by depositing such copy in the United States Post Office, Tallahassee, Florida, with first class postage prepaid, properly addressed to Talbot D'Alemberte and Jeffrey B. Crockett of Steel, Hector and Davis, the above named appellant's co-counsel of record at 1400 Southeast National Bank Building, 100 South Biscayne Boulevard, Miami, Florida 33131 and Richard B. Collins and Samuel R. Neel, III of Perkins and Collins, the above named appellant's co-counsel at Suite 702, Lewis State Bank Building, Tallahassee, Florida 32301.

All parties required to be served have been served.

Dated November 21st, 1983.

/s/ J. Robert McClure, Jr.
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Bartow Memorial Hospital, Inc.
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Cedars of Lebanon
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Miami, Florida 33136

Centro Asturiano Hospital
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Doctors General Hospital
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Doctors Hospital of Lake Worth, Inc.
341 Royal Palm Way
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ALEXANDER L. STEVAS,
CLERK

NO. 83-1262

In the Supreme Court of the United States

OCTOBER TERM 1983

SOUTHEAST VOLUSIA HOSPITAL DISTRICT, ET AL.,
Appellants

vs.

FLORIDA PATIENT'S COMPENSATION FUND, ET AL.,
Appellees.

ON APPEAL FROM A JUDGMENT OF THE FLORIDA SUPREME COURT

Alternative Motions to Dismiss Appeal or to Affirm Judgment Appealed

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No. 83-1262

in the

Supreme Court

of the

United States

OCTOBER TERM 1983

SOUTHEAST VOLUSIA
HOSPITAL DISTRICT, ET AL.,
Appellants

vs.

FLORIDA PATIENT'S
COMPENSATION FUND, ET AL.,
Appellees.

ON APPEAL FROM A JUDGMENT OF
THE FLORIDA SUPREME COURT

ALTERNATIVE MOTIONS TO DISMISS APPEAL OR TO AFFIRM JUDGMENT APPEALED

Appellees, the FLORIDA PATIENT'S COMPENSATION FUND and the STATE OF FLORIDA, DEPARTMENT OF INSURANCE, hereby move to dismiss the instant appeal from the judgment of the

Florida Supreme Court, reported at 438 So.2d 815 (Fla. 1983) as not presenting a substantial federal question, or in the alternative, to summarily affirm the judgment of the Florida Supreme Court on the ground that the questions on which the decision of the cause depend are so insubstantial as not to need further argument. These motions are made in one combined pleading, pursuant to Rule 16 of this Court's Rules.

INTRODUCTION

Appellants are hospital members of the Florida Patient's Compensation Fund ("Fund"), appellee, who are attempting to use "substantive due process" and equal protection arguments as a defense to their liability for deficit assessments found necessary for the Fund's solvency by the Florida Department of Insurance and the Florida courts. It is undisputed that the Fund needs the assessments to make payments on judgments or settlements of medical malpractice claims. Since the Fund only covers the portion of claims over $100,000, it follows the Fund only compensates seriously injured medical malpractice plaintiffs.

Appellant hospitals have fought the assessments for which they are contractually and statutorilly liable since 1981, mostly on a melange of state statutory interpretation and state constitutional law theories. Because the Florida courts occasionally apply an equal protection/due process analysis more searching than that applied in the federal courts, *e.g.*, *State v. Lee*, 356 So.2d 276 (Fla. 1978), the hospitals placed primary reliance on the *Florida* equal protection and due process clauses and cited Florida cases. Nonetheless, in their briefs to the Florida courts, the Hospitals did raise—in passing—

the parallel federal constitutional guarantees, citing one or two federal cases. These half-hearted arguments, like all the hospitals' other arguments, were rejected.

The hospitals concede that the issue is whether there was a rational basis for the legislature to decide as it did. The hospitals however, apply the "rational basis" test in a decidedly unfamiliar fashion. No factual evidence was advanced by the hospitals to show that the legislative scheme was irrational. The actions of the Florida legislature, on their face and in light of the statutory purposes set out in the preamble and other plausible purposes inferable from the statute, were plainly reasonable. For these reasons, this Court should summarily dispose of the Hospitals' specious challenge to the Fund statute's assessment provisions and grant one of these alternative Motions to Dismiss for Want of a Substantial Federal Question or to Summarily Affirm.

Nature of the Issues

The Florida Patient's Compensation Fund ("Fund") is a non-profit entity which exists to provide medical malpractice protection for Florida health care providers (hospitals and physicians) who choose to join it. The Florida Patient's Compensation Fund is one of a number of the Florida legislature's responses to the Medical Malpractice Crisis of 1975, when "there was an imminent danger that a drastic curtailment in the availability of health care services would occur in this state." *Carter v. Sparkman*, 335 So.2d 802, 805 (Fla. 1976) (holding another aspect of legislative response constitutional, and discussing legislative preamble). This Court must view the constitutionality of the statute at issue in

light of the Florida legislature's explicit findings of a crisis in the preamble to Ch. 75-9, Laws of Florida. *Quoted, Carter, supra*, 335 So.2d at 805-06.

Physicians and hospitals voluntarily choose whether or not to join the Fund after fees are set for the start of a Fund year, relying on the statutory terms of Fund membership, Fla. Stat. §768.54.

One of the terms of Fund membership is that if claims by medical malpractice plaintiffs against the Fund* exceed the fees paid by members for a particular Fund year,** (plus the interest the fees have earned), then the members will be liable for a deficit "assessment." This is the means that the Fund is kept solvent. It is undisputed that if these assessments are not paid, the Fund will be insolvent and unable to pay the judgments or settlements of medical malpractice plaintiffs against Fund members.

The appellant Hospitals do not contest the validity of the Florida Patient's Compensation Fund *per se*. Indeed, they have admitted that the concept of a state-regulated Fund of health care providers providing each other medical malpractice protection, although it might be novel or in some ways experimental, is well within the Legislature's power. Nor do the Hospitals complain that assessments are used to finance the Fund or argue

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*Fla. Stat. §768.54 provides that the Fund may be joined as a party defendant in lawsuits by medical malpractice plaintiffs against Fund members.

**Under the statutes, members join separately for different years, which are separate accounting units.

that an assessment is not properly due now. The hospitals are left to attack only one sentence of the fund statute, which concerns the allocation of assessments among Fund members. The statute, §768.54(3)(c), as amended in 1976, by Chapter 76-260, Laws of Florida, states that if a deficit assessment is necessary "to obtain the money necessary to meet all claims" for a particular Fund (fiscal) year, the assessment will be spread among Fund members on an actuarial basis, except that

> In no case shall any [deficit] assessment for a particular year against any health care provider other than [a hospital] exceed an amount equal to 2 times the fees originally paid by such health care provider for participation in the fund for the fund year giving rise to such [deficit] assessment.

The Hospitals would like to remove the sentence just quoted from the Fund statute. If physician assessments were not limited, hospitals' assessments would be lower. This Court, however, will not use the Equal Protection or Due Process clauses to release the Hospitals from their contracts, and so their appeal should be handled summarily.

I.

THE VOLUNTARINESS OF FUND MEMBERSHIP IS A "COMPLETE ANSWER" TO THE HOSPITALS' CONSTITUTIONAL ARGUMENTS

The key fact about Florida health care providers' membership in the Florida Patient's Compensation Fund is that it is voluntary. It is true that Florida hospitals

are compelled to be financially responsible, while Florida physicians are not. Nonetheless, Fla. Stat. §768.54(2)(c) (A. 78 of Hospitals' Appendix) at the relevant time allowed the Hospitals to meet this requirement in several ways: posting bond of not more than $2.5 million; placing not more than $2.5 million in escrow; or obtaining private insurance or self-insurance of no more than $2.5 million. It is undisputed fact, as found by the independent hearing officer below:

> The Fund is a private not-for-profit organization, *participation in which is totally voluntary for its member-health care providers.* Insofar as [the Hospitals] are concerned, membership in the Fund is but one of several options available to provide legally required evidence of financial responsibility in order to obtain licensure as a hospital in Florida. *In fact, of the approximately 260 hospitals in Florida, only 125 satisfy their financial responsibility requirement via membership in the Fund.*
>
> (A. 58 of Hospital's Appendix; Emphasis added).

The hospitals have argued that because they are required to be financially responsible, their membership in the Fund is not voluntary.* In view of the fact that *only half of Florida hospitals joined the Fund for the relevant year,* it is obvious that Fund membership is voluntary.

---

*The intermediate Florida appellate court seemed to agree with this argument, but the Supreme Court rejected it in holding the Fund satisfied due process because it "provide[s] medical malpractice protection for Florida health care providers *under terms accepted by the participants*". (A. 17 of Hospitals' appendix.)

This circumstance cuts off any need of this Court to examine the Hospitals' arguments. This is not a constitutional law case, but a contracts case. Private parties every day enter into contracts which might be unconstitutional if the state required them to be performed. Even a burdensome contract voluntarily entered into with a private entity created by statute, without more, raises no constitutional issue. Because the state courts have resolved the state law issue of whether the Department of Insurance has correctly interpreted the Hospitals' contractual/statutory obligation, there is no remaining issue for this Court. The statute at the time the Hospital joined provided warning that assessments for physicians would be limited to the amount of fees originally paid, while hospitals' assessments would not be so limited. The contract documents which each Hospital executed before it agreed to join the Fund plainly made the same point (A.3). These documents were in the record below and are ~~attached in the Appendix hereto (A.1-A.5).~~ Lodged

Precedent from this Court establishes that the Hospitals' decision to join the Fund *while the cap on physician assessments of which they complain was on the books* creates an estoppel against the Hospitals to challenge the Fund statute.* It is undisputed the Hospitals have received benefits from the Fund—many of their claims have been paid by the Fund for the Fund years in question. Moreover, the Hospitals are not offering to repay these payments or even turning down the defense

*Their voluntary decision makes it impossible, in our view, for them to prevail on the merits as well. If the statute were as irrational as they say, surely they would not have joined the Fund.

of pending suits in these Fund years by the Fund. The Hospitals have received and still are receiving benefits at the expense of the Fund. Therefore, they are estopped from claiming their part of the contract is illegal. A case from this Court that is closely on point is *Booth Fisheries Co. v. Industrial Commission of the State of Wisconsin*, 271 U.S. 208 (1926). In that case an employer challenged an award under Wisconsin's Workmen's Compensation scheme, after the employer had voluntarily elected to participate in the scheme. This Court summarily rejected its arguments:

> *A complete answer to this claim is found in the elective or voluntary character of the Wisconsin Compensation Act.* That act provides that every employer who has elected to do so shall become subject to the act . . . In view of such an opportunity for choice, the employer who elects to accept the law may not complain [of the specifics of the statute he elected to follow.]
>
> More than this, the employer in this case having elected to accept the provisions of the law, and such benefits and immunities as it gives, may not escape its burdens by asserting that it is unconstitutional. *The election is a waiver and estops such complaint.*

Id. at 210-11. (Emphasis added.)

Accord: Fahey v. Mallonee, 332 U.S. 245, 255-56 (1947); *Ashwander v. Tennessee Valley Authority*, 297 U.S. 288, 348 (1936) (Brandeis, J., concurring) ("The Court

will not pass upon the constitutionality of a statute at the instance of one who has availed himself of its benefits"). Because the undisputed voluntariness of the Hospitals' action is also a "complete answer" to all their objections to this Court, that circumstance is enough to mandate the dismissal of the appeal or summary affirmance of the judgment of the Florida Supreme Court.

Aside from constitutional estoppel principles, we note the Hospitals are trying to walk away from their contracts. Yet they have *at no point* done what is essential for rescission, that is, offer to place the other contractual parties in the *status quo ante*. Without the assessments, it is impossible to provide alternative insurance to other Fund members, or alternative means to pay victims of medical malpractice who are entitled to be compensated by the Fund. The Hospitals simply ignore these interests.

The Hospitals purport to rely on the principle that "legal burdens should bear some relationship to individual responsibility or wrongdoing". Jurisdictional Statement at 16-17. The illegitimacy cases quoted by the Hospitals are obviously irrelevant. The Hospitals are "responsible" for these assessments, not because of tort liability, to be sure, but because of the terms of their contract with the Fund. It is this contractual responsibility which is controlling here.

The Hospitals, in their factual statement, emphasize that "physicians" as a class are paying less to the Fund than the amount of claims filed against physicians. This so-called "subsidy" of physicians by Hospitals is the sole basis of the Hospitals' constitutional challenges. The Hospitals are missing the point. As they argue,

the Fund is "a kind of group self-insurance". Jurisdictional Statement at 6. Since there is an element of group self-insurance in the Fund, participants are liable for *each other's* claims under the terms of the agreement. The Fund provides "occurrence basis" coverage, so that (for example) those causing malpractice claims by treatment between July 1, 1977 and June 30, 1978 (the 1978 Fund year) will be "subsidized" by those Fund members who have no claims brought against them arising out of that time period. Can those who have no claims against them get a reimbursement of their fees, or avoid the liability for assessments set out in their contract? Even though these individuals have been careful, have been excellent risk managers, and have avoided all wrongdoing, the answer must be "no". The answer to the hypothetical complaint of the claimless Fund member is the same as to the Hospitals': "You don't argue that your contract was improperly interpreted, and so you are liable under the terms of your agreement." The "subsidy" inherent in any voluntary program of group self-insurance raises no constitutional issue. For this reason, this appeal should receive summary disposition from this Court.

The Facts of Fee-Setting In These Fund Years Do Not Help The Hospitals

The Hospitals spend much effort in describing how the Florida Patient's Compensation Fund came to need large assessments to pay the claims against it. These facts, however incompletely stated by the Hospitals, cannot aid the Hospitals who do not claim: (1) that they were not aware of the amount of fees when they joined the Fund (they were aware of the fees charged all Fund members); or (2) that the fees were improperly set in

violation of any federal constitutional norm (the Hospitals never even argued this below). In fact, the Insurance Commissioner made a good faith effort to set fees at an actuarially sound level but—disregarding the argument of the Fund and ruling with the very Hospitals who now complain—made an *erroneous prediction* on the level of future medical malpractice claims in Florida. The base fees for prior years had proved adequate, as is shown by the fact that these assessments were the first ever needed by the Fund. The major reason for the change that can be identified from this record is that medical mediation panels, *see Carter v. Sparkman*, 335 So.2d 802 (Fla. 1976), widely regarded as a significant barrier to medical malpractice plaintiffs' pursuit of their claims, were declared unconstitutional by the Florida Supreme Court in *Aldana v. Holub*, 381 So.2d 231 (Fla. 1980).

The Florida statute was worded in such a way that if the Insurance Commissioner, in his discretion, did not find higher "additional" fees necessary, the "base fees" set out in the statute, which were mandated for the 1975-76 Fund year, would go into effect. For the 1977-78 Fund year, these base fees went into effect with no one seeing any reason to raise the fees, which had proven satisfactory under prior (sparse) claims experience. For the 1978-79 Fund year, the Fund management itself, acting on the advice of an actuarial report, sought higher fees than base fees. Upon the Fund's petition to the Insurance Commissioner, a hearing was held and health care provider representatives—both physicians and hospitals—argued that higher fees were not necessary, in view of medical mediation panels and the still low claims experience of the Fund. *None of the hospitals now saying that higher fees should have been*

set argued that at the time. The hospitals therefore share the blame for the inaccuracy of the Insurance Commissioner's predictions. The Florida courts have held that because assessments are now required to meet claims, the historical reasons why an assessment is necessary need not be examined under state law. Should this Court examine them, the Hospitals cannot profit by their own error in opposing the higher fees sought by the Fund.

II.

THE HOSPITALS' EQUAL PROTECTION ARGUMENTS DO NOT WARRANT FULL CONSIDERATION BY THIS COURT

The Hospitals agree that the cap on physicians' assessments is a social or economic regulation which is governed by the extremely deferential "rational basis" test. Indeed, leaving aside *Zobel v. Williams*, 457 U.S. 55 (1982), whose "right to travel" implications make it clearly inapposite,* the only case in recent memory overturning an economic statute on equal protection grounds, *Morey v. Doud*, 354 U.S. 457 (1957), was overruled in *City of New Orleans v. Dukes*, 427 U.S. 297 (1976). The facts of this case certainly do not warrant reexamination of this court's consistent and long-standing unwillingness to second-guess plainly rational legislative economic judgments.

*The key to the *Zobel* case is the court's worry that if the classification in question (length of residence in a state) were valid, the state could condition all State benefits on that basis.

Equal Protection Standards

The well settled principles of the "rational basis" equal protection test can be briefly summarized:

> In the area of economics and social welfare, a state does not violate the Equal Protection Clause . . . merely because the classifications made by its laws are imperfect . . . As long as the classificatory scheme chosen by [the legislature] rationally advances a reasonable and identifiable governmental objective, we must disregard the existence of other methods of allocation that we, as individuals, perhaps would have preferred.
>
> *Schweiker v. Wilson*, 450 U.S. 221, 234-35 (1981)
>
> "When the classification in such a law [subject to review under the rational basis test] is called in question, if any state of facts reasonably can be conceived that would sustain it, the existence of that state of facts at the time that the law was enacted must be assumed" . . . [If there are] plausible reasons for [the legislative] action, . . . it is, of course, "constitutionally irrelevant whether this reasoning in fact underlay the legislative decision.'
>
> *United States Railroad Retirement Board v. Fritz*, 449 U.S. 166, 174 (1980)
>
> Although parties challenging legislation under the Equal Protection Clause may introduce evidence supporting their claim that it is

> irrational, [citation omitted], they cannot prevail so long as "it is evident from all the considerations presented to [the legislature], and those of which we may take judicial notice, that the question is at least debatable."
>
> *State of Minnesota v. Clover Leaf Creamery Co.*, 449 U.S. 456, 464 (1981)

As well-worn as these principles are, their application to this case would create no new law nor illuminate any uncertain areas. There is simply no reason for this Court to further consider this case.

The hospitals do manage to cite a handful of cases in their Jurisdictional Statement. Most of the cases involve improper or disapproved legislative purposes, such as discrimination against illegitimate children, non-residents, or aliens. The Hospitals at no point question the validity of the legislative goals in this case of reducing health cost care in Florida, and indeed approve this purpose at pages 19 and 22 of their Jurisdictional Statement. Therefore, the cases cited by the Hospitals are far off-point.

Purposes of the Physician Assessment Cap

The physician assessment cap was added by Chapter 76-260, Laws of Florida, as the Florida intermediate appellate court realized, "to offer greater protection for physicians," as a means of lowering health care costs. *Southeast Volusia Hosp. v. State, Dept of Ins.*,

432 So.2d 592, 595 (Fla. App. 1 Dist. 1983). The statutory preamble states:

> WHEREAS, despite the responsive and responsible actions of the 1975 session of the Legislature, professional liability insurance premiums for Florida *physicians* have continued to rise and, according to the best available projections, will continue to rise and, according to the best available projections, will continue to rise at a dramatic rate, and
>
> WHEREAS, insurance companies across America are continuing to withdraw from the medical professional liability insurance market so that such insurance, even at exorbitant rates, is becoming virtually unavailable in the voluntary private sector, and
>
> WHEREAS, the maximum rates for essential medical specialists such as cardio-vascular *surgeons, neurosurgeons, orthopedic surgeons,* and *anesthesiologists* range from $8,200 in *physician*-owned trusts to $24,000 through the JUA, and
>
> WHEREAS, a certain amount of these premium costs are passed on to the consuming public through higher costs for health care services in addition to the heavy and costly burden of "defensive medicine" as *physicians* are forced to practice with an overabundance of caution to avoid potential litigation, and

WHEREAS, this insurance crisis threatens the quality of health care services in Florida as *physicians* become increasingly wary of high-risk procedures and are forced to downgrade their specialties to obtain relief from oppressive insurance rates, and

WHEREAS, this crisis also poses a dire threat to the continuing availability of health care in our state as new *young physicians* decide to practice elsewhere because they cannot afford high insurance premiums and as *older physicians* choose premature retirement in lieu of a continuing diminution of their assets by spiraling insurance rates, and

WHEREAS, our present tort law/liability insurance system for medical malpractice will eventually break down and costs will continue to rise above acceptable levels, fundamental reforms of said tort law/liability insurance system must be undertaken, and

WHEREAS, the continuing crisis proportions of this compelling social problem demand immediate and dramatic legislative action . . . (Emphasis added. A. 27 of Hospitals' Appendix).

It is apparent that the immediate purposes of the physician cap on assessments are to lower the (1) cost and (2) uncertainty of medical malpractice protection for Florida *physicians*. To encourage physicians to locate or remain in Florida, to discourage costly defensive medicine, and to attempt to control ultimate health care costs to consumers are plainly legitimate state objectives.

The Florida Supreme Court held the statute valid against equal protection objections in language fully consistent with this Court's jurisprudence:

> [The Department of Insurance and the Fund] contend that hospitals and physicians are not similarly situated and we agree. While both may fall under a general classification, health care providers, they clearly are not similarly situated. *Hospitals are corporate entities with larger budgets and much larger numbers of patients over which to spread costs.* There are numerous differences between the two which justify the different treatment of these two groups by the statute.
>
> *Department of Ins. v. Southeast Volusia Hosp. Dist.*, 438 So.2d 815 at 821 (Fla. 1983) (Emphasis added)

The decision of the Florida Supreme Court was correct and fully consistent with the cited principles of this court's constitutional jurisprudence. Indeed, in light of the purposes of the statute, there are at least *five* rational bases for a distinction between hospitals and physicians—all effectively admitted by the Hospitals—any one of which is sufficient to summarily dispose of the constitutional issue over which the Hospitals wish this Court to linger.

A. It was Rational For the Legislature to Believe Hospitals Are Better At Spreading the Costs of Medical Malpractice Premiums to the Health Care Consumer.

The Fund statute provides that assessments of Fund members are the means by which the Fund would be financed. Ultimately the total assessment must be paid by Florida health care consumers, and so how it is distributed to them is a matter of constitutional indifference. The Hospitals admit they have larger budgets. Jurisdictional Statement at 20-21. The legislature was rational in believing that hospitals with these larger budgets could more easily absorb the shock of a large assessment and pass it on to the ultimate Florida health care consumers.

B. It Was Rational For the Legislature to Believe That Minimization of Medical Malpractice Costs and Uncertainty Was More Important For Physicians Than For Hospitals.

The legislature was reasonable in believing that physicians would be more likely to practice wasteful defensive medicine, limit their practice, or even move out of state if their assessment liability were not limited. As the Hospitals admit, Jurisdictional Statement at 21, hospitals are permanent (or nearly permanent) fixtures in their communities and will continue to provide medical care regardless of their assessment liability. Hospitals are already greatly involved with government grants and government-imposed costs. This Court only recently, in *Revere v. Massachusetts General Hospital*, ____ U.S. ____, 77 L.Ed 2d 605, 103 S.Ct. 2979 (1983), noted that

> Many hospitals are subject to federal or state laws that require them to provide care to indigents. Hospitals receiving federal grant money under the Hill-Burton Act, for example, must supply a reasonable amount of free care to indigents. [Citation omitted.] In the Commonwealth of Massachusetts now, any hospital with an emergency room facility must provide emergency services regardless of the patient's ability to pay. [Statutes cited] Refusal to provide treatment would subject the hospital to malpractice liability.
>
> *Id.*, 77 L.Ed. 2d at 611-612.

Just as these regulations raised no federal constitutional question, the assessment allocation scheme Florida has decided to employ for the Fund raises no such issue.

C. It Was Rational For the Legislature to Believe that Physicians Would Not Join the Fund Without A Cap on Assessments.

Under the Florida statutes, hospitals are required to be "financially responsible" either through Fund membership, or some other means. Physicians, on the other hand, are subject to no similar constraint. If the physicians' assessment liability were not carefully limited, therefore, physicians might not join the Fund, instead entering the ranks of Florida physicians who take the risk of foregoing medical malpractice protection. The legislature could rationally have believed that physicians would not have joined the Fund if there were unlimited liability for assessments. This would have thwarted

another key purpose of the Fund statute – as the Fund's title indicates – providing a means of *compensating Florida patients* with medical malpractice claims. The Fund can only compensate, of course, for the actions of its members, and then only if enough Florida health care providers join to make it an actuarially sound risk spreading device. The Legislature could rationally have believed that the cap on physician assessments would encourage more physicians to join the Fund rather than go without medical malpractice protection. This is enough by itself to validate the challenged classification.

D. It Was Rational For the Legislature to Believe Hospitals Are A Proper Focus For Medical Malpractice Prevention.

The Hospitals admit that "if placing the burden of physician malpractice on hospitals is rationally related to the goal of lower medical malpractice insurance cost for health care providers in general, including hospitals and their patients," then the Statute would be constitutional. Jurisdictional Statement at 22-23. This is not a necessity, of course, because Fund membership is voluntary. Even if the legislature had *required* the hospitals to join the Fund, however, the differential assessment scheme could be upheld on the precise basis admitted by the Hospitals. It is the challengers' burden to establish that a classification is irrational. All the evidence in this proceeding supports the rational legislative assumption that placing costs of medical malpractice on hospitals would place it on entities which can reduce malpractice costs. If hospitals are responsible for the bulk of assessments, they have an incentive to lower the incidence of medical malpractice.

It is undisputed that 80% of all malpractice claims originate in hospitals. In-house physicians, concededly under the full control of hospitals, can be used to limit the incidence of malpractice claims in any manner directed by the hospital. Even a staff ("independent contractor") physician cannot practice in a hospital without the hospital's approval. The Insurance Commissioner noted below that evidence was presented that "hospitals could revoke the staff privileges of physicians not complying with risk management programs implemented by the hospitals." Final Order at 11. (Hospitals' appendix at A40). Even if, as the Hospitals have argued, it is difficult to deny hospital privileges to staff doctors who have erred, this does not mean that preventative work rules cannot attain the desired result of minimizing malpractice claims. *See* Fla. Op. Atty. Gen. 078-25 (county hospital may require staff physicians to comply with rule "bearing a reasonable relationship to the hospital's operation purpose and to its . . . responsibility to its patients and their care and well-being"). Florida law requires hospitals to have "risk management" programs to control both staff and independent contractor physicians. Fla. Stat. §768.41 and §95.065.

There is therefore ample reason to believe that hospitals can identify and control the occurrence of incidents in hospitals which ultimately result in malpractice claims. Even if there were a legitimate conflict of opinion on such factual matters, the courts are obliged to uphold the statute against a constitutional challenge. It is in the power of hospitals to optimize expenditures on prevention of medical malpractice. This circumstance alone is enough to validate the statute on the points at issue.

E. It Was Rational For the Legislature To Believe That Hospitals Were Liable Under State Law For Many Malpractice Claims Brought Against Physicians.

The hospitals have made much of the argument that they are paying for claims brought against physicians. Because 80% of claims arise out of incidents in hospitals, there is only one reason why more claims are not against hospitals—plaintiffs have not joined hospitals as defendants. If the Fund were unavailable as a solvent means of payment, plaintiffs would more often join Hospitals in tort suits. The legislature was doubtless aware that many of the "claims" viewed in the Fund's records as attributable to physicians would be, in the eyes of the law, also attributable to hospitals.

Robert Atkins, the Hospitals' key witness below, admitted that the hospital emergency room is one of the most fertile sites of malpractice claims. The plaintiff in such a case will probably sue the physician, if he is financially responsible, but the hospital will also be liable as holding itself out to provide emergency care. *Irving v. Doctors Hospital of Lake Worth, Inc.*, 415 So.2d 55 (Fla. 4th DCA 1982) (especially page 57 n.2).

Even in the non-emergency room situation, whether a negligent physician is an agent of the hospital, making the latter vicariously liable for the torts of the former, is a jury matter. *Pinillos v. Cedars of Lebanon Hospital Corp.*, 403 So.2d 365, 368-69 (Fla. 1981); *Webb v. Priest*, 413 So.2d 43, 47 n.2 (Fla. 3d DCA 1982).

There was testimony below that the trend of Florida law was toward greater vicarious liability of hospitals

for physician negligence; and, of course, to the extent that hospitals have the right to control situations which cause malpractice claims, liability can be based directly on negligence rather than on the theory that the doctor is an agent of the hospital. It was rational for the legislature to have believed hospitals would be liable for many *physician* malpractice claims and therefore that it is fair to require hospitals to pay for them.

These reasons are all rational and plausible, and therefore the Hospitals' challenge to the cap on physician assessments cannot succeed.

III.

THE HOSPITALS RAISE NO DUE PROCESS ISSUE WARRANTING THIS COURT'S CONSIDERATION

As this Court held in *Usery v. Turner Elkhorn Mining Co.*, 428 U.S. 1 (1976),

> legislative Acts adjusting the burdens and benefits of economic life come to the Court with a presumption of constitutionality, and . . . the burden is on one complaining of a due process violation to establish that the legislature has acted in an arbitrary and irrational way.
>
> *Id.* at 15.

The analysis under the equal protection clause and due process clauses is therefore identical—if there is a plausible, rational, reason which could justify the Legislature's actions, the statute will be sustained under both clauses of the Fourteenth Amendment.

The *Turner* case, just-cited, shows that the cap on physician assessments is valid. In *Turner*, the legislature required that employers pay for the expenses of black lung disease suffered by their employees. In the instant case, the legislature has decreed that hospitals (who voluntarily join the Fund) pay in some circumstances for some malpractice claims attributable in the first instance to physicians. The holding of this Court in *Turner* is applicable to our situation: "It is enough to say that the Act approaches the problem of cost-spreading rationally; whether a broader cost-spreading scheme would have been wiser or more practical under the circumstances is not a question of constitutional dimension." *Id.* at 19. For the reasons discussed, *supra*, the Florida legislature approached the problem of spreading the costs of medical malpractice in a rational way.

The Hospitals attempt to distinguish *California State Automobile Ass'n Inter-Insurance Bureau v. Maloney*, 341 U.S. 105 (1951). The case is distinguishable from the instant case, but not for any of the reasons cited by the Hospitals. In *Maloney*, this Court approved a California statute which required all insurers doing business in the State to join together and insure "poor risks", with the cost to be equitably divided by the State Insurance Department. The constitutional issue in *Maloney* arose because the plan was a *mandatory* one, with the insurance companies *required* to participate on terms dictated by the State. In our case, on the other hand, the particular group of Hospitals who are now Appellants voluntarily joined the Fund and therefore accepted the terms of the legislature's invitation. The voluntary acceptance of the statute's terms makes their due process argument frivolous.

CONCLUSION

Essentially, the Hospitals are challenging a plainly rational economic regulation. The Hospitals were absolutely unsuccessful in raising their federal constitutional claims below, and this Court has denied the Hospitals' motion for stay of the mandate despite the Hospitals' uncontested assertion that

> If the stay is denied, the FPCF has declared that it will proceed to collect the more than $12 million in assessments from the hospitals that are parties to this appeal, and will immediately disburse *all* such funds to physician malpractice plaintiffs having claims against the Fund, whether through judgment or settlement. [citation omitted.] Because all amounts paid by Appellants will immediately be disbursed, there is no source from which they can be repaid.
>
> "Emergency Application for Stay" at 6.

Apparently this Court has concluded that the Hospitals' chances of prevailing are so remote that a stay was not justified, even though without it the Hospitals could not be given practical relief by an eventual victory in this Court.* Full briefing is not necessary, and Appellees' Motion to Dismiss For Want of A Substantial Federal

*This fact situation might be such that this appeal could be dismissed as moot. Because it is so clear that the Florida Supreme Court correctly decided the federal constitutional questions before it, appellees do not rely on this ground in urging this Court to terminate this groundless appeal.

Question or Motion to Summarily Affirm should be granted.

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that three true and correct copies of the above and foregoing Alternative Motions to Dismiss Appeal or to Affirm Judgment Appealed and attached Appendix was mailed this 29th day of February, 1984 to the addressees listed on the attached Service List.

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No. 83-1262

In the Supreme Court of the United States

October Term, 1983

SOUTHEAST VOLUSIA HOSPITAL DISTRICT, et al.,
Appellants,

vs.

FLORIDA PATIENT'S COMPENSATION FUND, et al.,
Appellees.

ON APPEAL FROM THE SUPREME COURT OF FLORIDA

BRIEF IN OPPOSITION TO APPELLEES' ALTERNATIVE MOTIONS TO DISMISS APPEAL OR TO AFFIRM JUDGMENT

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BRIEF IN OPPOSITION TO APPELLEES' ALTERNATIVE MOTIONS TO DISMISS APPEAL OR TO AFFIRM JUDGMENT

Appellants[1] file this brief in response to the Appellees' Alternative Motions to Dismiss Appeal or to Affirm Judgment Appealed.

I. Response to Arguments in Appellees' Point I - the Court Should Decide This Case on the Merits.

Although Appellees argue the same estoppel grounds they asserted below, it should be noted that the Florida Supreme Court did not decide this case on those grounds. Instead, the Florida Supreme Court interpreted the statute and then faced squarely the constitutional issues raised here. Those issues were decided erroneously, and this Court should review those issues on appeal.

1. The names, parents and subsidiaries of corporate appellants appear at A1 of the Jurisdictional Statement.

A. Joining in the Fund does not estop the hospitals from complaining of an unconstitutional interpretation or application of the Statute.

Appellees argue that the mere fact the Hospitals joined the fund estops them from contesting either the unconstitutional application or interpretation of the statute. Such a rule of law would produce absurd results. If that were the law, neither party to a contract could challenge the other's interpretation of it, and no person affected by a statute could complain that it was being unconstitutionally interpreted or applied.

It may be true, as appellees suggest, that the hospitals would have attempted to find other means of meeting their obligations of financial responsibility if they had known at the outset that the Insurance Commissioner and the Florida courts would interpret and apply the statute as they have. In fact, once the state's interpretation of the statute became known, all hospitals withdrew from the Fund. Nevertheless, they are left with approximately $190,000,000 of physician liability for the years that they were members of the Fund.

The reasons that the hospitals could not have anticipated the particular interpretation and application of the statute appealed from included the provisions of the statute that: (1) hospitals are to be a separate risk classification from doctors; (2) "fees" are to be set based on actuarial considerations, and (3) assessments are to fairly reflect the same classifications in the Statute, including the separate risk categories for hospitals. Appellees argue that the hospitals should have known from the beginning (and therefore voluntarily consented to) the State's interpretation which allowed actuarially inadequate fees for physicians, with the difference to be made up by hospitals through the assessment process. Such an interpreta-

tion renders the above provisions meaningless, and should not reasonably have been anticipated.

This is in no sense a case that can be summarily decided on the theory that the hospitals have previously waived their rights to protest the unconstitutionality of the statute as interpreted and applied. The Florida District Court of Appeal rejected Appellees' suggestion that the hospitals can be considered volunteers. It was not only the expense, but the unavailability in the marketplace of medical malpractice insurance, that prompted the creation of the Fund in the first place. The District Court held (Appendix to Jurisdictional Statement at 31) that the acceptance of the general benefits of an act does not estop a party to challenge the constitutionality of a separable portion thereof, such as the funding provisions here, and further held that the acceptance of benefits of an act under compulsion did not preclude an attack upon the Statute itself. The court specifically found that the exemptions from the compulsory membership provisions of the act were not realistic alternatives (*See* A31-32). Although the Appellees suggest that the Florida courts *could have* decided on purely state estoppel grounds, they did not. This Court should not assume an additional state court rationale, rejected by the Florida courts, in order to defeat its plain jurisdiction.

Appellees argue that this is a contract case, and that a Fund pamphlet and application form mentioned unlimited liability of hospitals for assessments. Their argument overlooks that fact that the statute is part and parcel of any contract,[2] and in any event, it is clear that constitutional

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2. E.g., *Mullis v. State Farm Mutual Automobile Insurance Co.*, 252 So.2d 229 (Fla. 1971); *Southeast Title & Insurance Co. v. Carrico*, 202 So.2d 179 (Fla. 1967); *Sellers v. United States Fidelity & Guaranty Co.*, 185 So.2d 689, 690 (Fla. 1966); ("[i]f the statute is to be meaningful and controlling . . ., all inconsistent clauses in the policy . . . must be judicially rejected").

rights are not waived by entering into contracts. For example, in *Sambo's Restaurants, Inc. v. City of Ann Arbor*, 663 F.2d 686 (6th Cir. 1981), a would-be Sambo's restaurant, responding to objections that the name "Sambo's" had racial overtones, agreed to use another name in return for a site plan approval. The restaurant owners later sought to use the name Sambo's by asserting their First Amendment rights to commercial speech, which the Sixth Circuit ruled were not waived by such an agreement. Here the hospitals have not waived their right to complain of an unconstitutional interpretation and application which eliminates the fundamental actuarial soundness requirement of the statute.

Appellees suggest that the hospitals are victims of a dilemma: That having entered into a contract incorporating an ambiguous statutory provision, the hospitals cannot complain of an unconstitutional interpretation or application of that statutory provision. Further, they suggest that the hospitals are attempting to rescind their contracts without offering to put the parties back in status quo. Contrary to Appellees' argument on page 9, this is not a rescission case. The hospitals are complaining here that the statute has been interpreted and applied in an unconstitutional manner, and they are entitled to relief from this Court on appeal.

B. Response to the suggestion that the hospitals contemplated subsidizing each other, therefore they cannot object to subsidizing physicians.

Appellees suggest on pages 9 and 10 of the motions that any kind of self-insurance involves spreading risks and argue that the hospitals therefore cannot object to paying physician losses. The argument ignores the language of the statute requiring separate risk categories for hospitals.

C. Response to factual assertions concerning fee setting.

Inaccurate factual assertions underlie Appellees' Arguments at pages 10-12 of their motion:

(1) It is contrary to the record that the Insurance Commissioner made a good faith effort to set fees or that base fees for prior years had proved adequate. Plainly, all monies generated by insurance premiums are not needed immediately to pay claims. The claims must first occur and be processed at least to the point of settlement. That is why cash deficiencies did not occur until the Fund had been in operation for several years, not because there was actuarial evidence that the "base fees" would be adequate without the "additional fees" required by the statute.

(2) The record will show that the Insurance Commissioner rejected the only actuarial information that he had before him, *not* that he made a good faith erroneous prediction on conflicting actuarial reports.

(3) There is no evidence that the unconstitutionality of the medical mediation panel provisions of the statute created the deficiencies in the Fund.

(4) It should not have been left to the Insurance Commissioner's sole discretion whether the fees should be increased—instead the statute required the Fund to report to the Insurance Commissioner on actuarially indicated rates and the Insurance Commissioner to take actuarial evidence and set actuarially sound fees.

(5) The representation that a hearing was held and that both physicians and hospitals argued that higher fees were not necessary is misleading and inaccurate. The record will show that in 1978 the Fund requested the In-

surance Commissioner to set higher physician fees (up to $12,000). The Commissioner did not do this, but rather charged all physicians only the $500.00 base fee. Although a hearing was held, the record will show that it was held in 1978 and that:

(a) The 1978 public hearing was announced as being "in the nature of a public fact finding inquiry" *not* a final hearing to resolve questions of interpretation of the statute under Florida's Administrative Procedures Act.

(b) The hospital representatives who were present, such as Atkins, testified *only as to hospital fees*, and spoke only for the proposed hospital rates, not physician rates,[3] thereby appropriately recognizing the statute's different "classifications." Atkins' testimony supported actuarially sound *hospital* rates. The arguments that the low *physician* rates were the result of *hospital* action is nowhere supported in the record.

(c) Although *some* representatives of *some* hospitals appeared at the public hearing involving the Fund's request for an actuarial increase for the 1978-1979 Fund year, they also complained of the insufficient notice to the individual members of the Fund (R 1367-1372), and the record is clear that all hospitals were neither represented nor notified.

(d) A fair reading of the 1978 order (R 1310) shows that the request for additional fees was denied because it was *premature*, there not having been sufficient experience with the Fund, and the Fund not being in danger

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3. "I speak only as this rate request applies to hospitals, because I have not studied the physician question." (Incidentally, it appears Mr. Atkins was correct in his position that the hospital fees at $300 per bed were actuarially sound. The deficits caused by hospital claims are insignificant.) (Respondent's Exhibit 10 at 42, R 1401.)

of immediate cash shortage. The conclusion of the 1978 order is that any change of existing fee structure "*is inappropriate at this time.*" The order is not titled as a final order and cannot fairly be construed as a "final agency action" interpreting of the statute as prohibiting actuarially sound fees for 1978 once more experience was gathered. The order contains no hint that four years later it would be construed as a "forever" final interpretation of the statute or an actuarial *setting* of fees rather than a decision to *postpone* the decision. Moreover, there is *no* Department *Rule* giving any hint that hospitals should have been prepared at such a "public fact finding inquiry" to give actuarial evidence on *physician* fees or that the "inquiry" should be treated as an adversary proceeding. *Aurora Pump v. Goulds Pumps, Inc.*, 424 So.2d 70 (Fla. 1st DCA 1982) disapproved unwritten or unpublished rules as a basis for determining rights before an administrative body.

(e) The argument does not in any event apply to the 1977 year (nor to any other fund year which is the subject of assessments sought to be levied subsequent to those directly involved in this case). Appellees do not explain and cannot logically justify the failure to set additional fees and at the same time argue that the hospitals are barred from demanding that they do so.

(f) Most important, the state courts rejected all of the estoppel or waiver arguments asserted by Appellees and decided the underlying issues of statutory interpretation and constitutionality. This Court has jurisdiction to review the determination of constitutionality. It should resist the temptation to decide the case on state grounds rejected by the state courts.

II. Response to Points II and III - the Equal Protection and Due Process Issues Are Substantial.

A. Reply to hypothetical justifications for the Statute.

Appellees' series of speculative justifications for the statute as interpreted and applied will not bear scrutiny. The suggestions that hospitals are bigger than doctors or that they usually are corporations do not eliminate constitutional protections. *Prudential Health Care Plan v. Commissioner of Insurance*, 626 S.W.2d 822, 831-33 (Tex. 1981) (imposing increased regulatory fees on corporation violates equal protection).

The argument that hospitals are where physicians engage in most of their malpractice does not rationally make hospitals responsible. The same logic would make the State Road Department responsible for all automobile claims because most accidents occur on roadways; the picture of the hospital administrator looking over the surgeon's shoulder telling him what he is doing wrong is ludicrous.

Speculation that the legislature may have believed that hospitals should pay the burden for physician malpractice because they can control claims through risk management also does not bear up under examination. Although proper risk management is desirable, requiring hospitals to bear physician malpractice costs bears no relationship to a risk management program. It may be theoretically true, although it is not practically true (T. 472-479; 519-526), that hospitals can revoke staff privileges of physicians not complying with risk management programs. *However, revoking staff privileges does not revoke licenses to practice*, and under the statute as interpreted if an expelled physician wants to join the Fund, the hospitals have to pay for his mal-

practice *whether he is on a member hospital's staff or not.* And if it were the legislative reasoning that hospitals should be responsible for doctors' acts, why limit the legislation to hospitals/doctors who happened to be members of the Fund?

Appellees suggest that there is no unfairness because hospitals may really be liable even if they are not sued. They speculate that a physician may be found to be an agent of a hospital, therefore, hospitals ought to be assessed liability for all physicians' claims regardless of whether the hospital is in fact found liable. Not only is this contrary to actuarial requirements—classifications should not be assessed because claims *might* be made when statistically they are not—but it is a reversal of the legal relationship between principal and agent. The agent who is negligent is liable to indemnify his principal, *not* vice versa! The real answer to the appellants' suggested rationale, however, is that the legislature did not make such findings, and the Court should not speculate that it did.

CONCLUSION

For the reasons set forth herein and in the Jurisdictional Statement, the Court should note probable jurisdiction.

Respectfully submitted,

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